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May-June 1974

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When cardiac complaints occur in the absence of organic findings, underlying anxiety may be one factor



The influence of anxiety on heart function

Excessive anxiety is one of a combination of factors that may trigger a series of maladaptive functional reactions which can generate further anxiety. Often involved in this vicious circle are some cardiac arrhythmias, paroxysmal supraventricular tachycardia and premature systoles. When these symptoms resemble those associated with actual organic disease, the overanxious patient needs reassurance that they have no

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Indications: Relief of anxiety and tension occurring alone or accompanying various disease states.

Contraindications: Patients with known hypersensitivity to the drug

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; with withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.

Precautions: In the elderly and debilitated, and in children over six limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, in combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precaution

organic basis and that reduction of excessive anxiety and emotional overreaction would be medically beneficial.

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in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

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Overview

Admissions Committee Picks Class of 1978

Stephen J. Miller, associate dean for admissions at HMS, announces that there were 3,258 applicants for the 165 places in the Class of 1978 at Harvard Medical School. Fifty-four women and 111 men have accepted the places offered them.

Of those offered places, 12 are from Radcliffe College and 35 from Harvard College. Twenty-five of those accepted will be enrolled in the Harvard-Massachusetts Institute of Technology Program in Health Sciences and Technology. Thirty-five of those offered places are classified as members of minority groups — American Indian, Black, Mexican American, Puerto Rican, and Orientals. Nine are alumni offspring.

Family Medicine and Primary Care at HMS

Maldistribution of physicians by geography and particularly by specialty of practice has certainly accentuated, if not caused, an apparent shortage of doctors in the United States. By comparison with the ordered planning of the British health system, Americans suffer from a surfeit of specialists.

This is a growing concern of specialty societies, such as the American College of Surgeons and of accrediting agencies, such as the Liaison Committee on Graduate Medical Education. These and other organizations are searching for a way to redirect voluntarily at least one half of all medical school graduates toward careers in primary care.

One response has been the remarkably rapid growth within a few short years of the specialty of family practice, with a proliferation of residency training programs and courses in family medicine

for medical students, as described by Charles A. Janeway, M.D. in his paper elsewhere in this issue of the *Bulletin*. Harvard should be proud of its pioneering role in developing the fundamental tenets of family medicine and of its fellowship program which trained some of the first directors of departments of family practice in the U.S.

Unfortunately, at present, there is no accredited graduate education program in family practice at any of the teaching hospitals affiliated with the Harvard Medical School. Unless planning for such a residency at one or more of the hospitals is brought to early fruition, the very popular medical student course in family health care will be handicapped. Other new approaches to the education of more primary care physicians are outlined in the papers of Stephen Goldfinger, M.D., Alan Goroll '73, and Richard Winickoff, M.D. These may

well become the prototypes for the majority of graduate education trainees in internal medicine in the future.

There is a need for as many qualified residencies as possible in both family practice and internal medicine primary care. When present in the same medical school, each can strengthen and compliment the other, as has happened at the University of Rochester School of Medicine and Dentistry.

In his welcome to the Harvard Medical Alumni in June 1972, Dean Robert H. Ebert challenged the School to develop programs of education in primary care. Is it not time for the Harvard Medical School to promote with vigor training programs in both family practice and internal medicine primary care?

Perry J. Culver '41

Internship List

In general, all internships and residencies* start July 1, 1974 for one year.

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New York, *Medicine*

Warren J. Adams
University of Michigan Affiliated Hospitals,
Ann Arbor, *Surgery*

Donald T. Allegra
University of Colorado Affiliated Hospitals,
Denver, *Medicine*

Louis M. Alpern
Hartford Hospital, Hartford,
Connecticut, *Rotating*

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Los Angeles County Harbor General
Hospital, Torrance, *Medicine*

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University of Michigan Affiliated Hospitals,
Surgery

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Durham, *Surgery**

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*Surgery**

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The Cambridge Hospital,
Medicine

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San Francisco, *Surgery**

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Rotating

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Medicine

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Medicine

Lawrence R. Berger
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*Pediatrics**

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Obstetrics/Gynecology

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*Pediatrics**

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Center, Portland, Oregon, *Medicine*

F. Richard Bringham
Massachusetts General Hospital,
Medicine

Charles A. Brown
Massachusetts General Hospital,
Medicine

William T. Brown
Roosevelt Hospital,
New York, *Medicine*

Jack D. Burke, Jr.
Massachusetts Mental Health Center,
*Psychiatry**

Robert P. Cabaj
The Cambridge Hospital,
*Psychiatry**

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University of Utah Affiliated Hospitals,
Salt Lake City, *Medicine*

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Bellevue Hospital Center of NYU,
Medicine

Alfred E. Chang
Duke University Medical Center,
*Surgery**

Kenneth W. Chin
University of California Hospitals,
Los Angeles, *Medicine*

Curt I. Civin
Children's Hospital Medical Center,
*Pediatrics**

Mark W. Clark
Massachusetts General Hospital,
Medicine

Martin G. Cogan
Mt. Zion Hospital,
San Francisco, *Medicine*

Beverly G. Coleman
University of Michigan Affiliated Hospitals,
*Radiology**

Stephen F. Cooper
Los Angeles County — USC Medical
Center, *Obstetrics/Gynecology*

John F. Cramer
University of Colorado Affiliated Hospitals,
Medicine

Andrew J. Czulewicz
Case Western Reserve Affiliated Hospitals,
Cleveland, *Surgery*

Harold Dash
San Francisco General Hospital,
Medicine

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The New York Hospital,
Medicine

Alfred DeMaria
Montefiore Hospital Center,
New York, *Medicine*

John R. Delfs
Los Angeles County Harbor General
Hospital, *Rotating*

John H. Demenkoff
Virginia Mason Hospital, Seattle,
Washington, *Medicine*

Gary R. Donovan
Syracuse Medical Center,
Rotating

Daniel B. Doyle
The Cambridge Hospital,
Rotating

Philip I. Elkin
San Francisco General Hospital,
*Family Practice**

Alan T. Elliot
Boston City Hospital,
Medicine

John F. Erkinen
Mary Hitchcock Memorial Hospital, Hanover,
New Hampshire, *Medicine*

Paul A. Fallon
Massachusetts Mental Health Center,
*Psychiatry**

Leslie S-T Fang
Massachusetts General Hospital,
Medicine

David J. Fink
Massachusetts General Hospital,
Medicine

Seth P. Finklestein
The New York Hospital,
Medicine

Henry D. Gaines
Johns Hopkins Hospital,
Baltimore, Maryland, *Medicine*

Hasan Garan
Hospital of the University of Pennsylvania,
Philadelphia, *Medicine*

Stuart M. Garay
Mt. Sinai Hospital,
New York, *Medicine*

Harry R. Gibbs
David Grant Memorial Hospital, Fairfield,
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Stewart L. Gilbert
Los Angeles County Harbor General
Hospital, *Medicine*

Thomas T. Gilbert
Highland Hospital, Rochester,
New York, *Family Practice**

Howard H. Goldman
Brandeis University/Worcester State
Hospital/Worcester Youth Guidance Center,
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*Family Practice**

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Medicine

Francis L. Griffin
Roosevelt Hospital,
Medicine

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Johns Hopkins Hospital,
Medicine

Robert L. Gross
New England Deaconess Hospital,
Medicine

Peter R. Hammond
Lincoln Hospital, New York,
Medicine

David C. Harmon
Rhode Island Hospital, Providence,
Medicine

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Medicine

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Seattle, Washington, *Pediatrics**

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Family Medicine and Primary Care at HMS

Family Medicine at Harvard

by Charles A. Janeway, M.D.

Thomas Morgan Rotch Professor of Pediatrics

Introduction

That an organized system of primary health and medical care, accessible to all, is a major deficiency of American medicine has become increasingly apparent during the last decade. To combat this, the Harvard Medical School, led by Dean Ebert, has undertaken programs aimed at correcting this deficiency — first, the Harvard Community Health Plan as an organized group practice and now postgraduate training for primary care by the Departments of Medicine at the Massachusetts General, Peter Bent Brigham, and Beth Israel Hospitals. These programs are a logical adaptation of the overwhelming trend toward specialization in American medical education, orienting the training of residents preparing for specialist careers as internists and pediatricians towards the primary health care needs of adults and children.

However, in most parts of the country, the change in educational program has been directed more towards the development of a new kind of specialist to play the primary care role — namely, the family physician. This is a logical outgrowth of the recommendations of the Millis report, published in 1966, which proposed the development of specially trained general physicians to replace the vanishing and usually poorly trained general practitioner of the past. It has obtained legitimacy through the establishment of the American Board of Family Practice as a result of the efforts of the American Academy of Family Practice, which has replaced the former Academy of General Practice; and it has received financial support from the Public Health Service, which administers federal funds to support education and training in family medicine.

That Harvard has pioneered in this movement towards family medicine through its Family Health Care Program is not always appreciated, and that the Harvard Medical School, in its important role of educating many future leaders of medical practice and medical education, should even participate in such a development is still under debate. It is our feeling that, since both doctors and patients differ in their desires and satisfactions, and since conditions differ widely in different parts of the country, both types of primary care physicians — pediatricians and internists on the one hand, and family physicians on the other — are needed. If so, we feel that our students should have the opportunity for contact with role models of both types, teachers for both sorts of careers should be produced, and research should include studies of the comparative effectiveness of these two methods of providing primary health care. Moreover, the developing discipline of family medicine, defined as that body of knowledge, based largely on epidemiology and the social and behavioral sciences, which looks at the family (defined broadly) as the focus of clinical study and care, needs to be developed as the scientific foundation for effective primary health and medical care.

Educational Aspects of the Family Health Care Program

The Family Health Care Program at HMS was established in 1954, with the encouragement of Dean Berry and support from generous grants from the Commonwealth Fund. The concept grew out of attempts at The Children's Hospital to strengthen the education of

future pediatricians in the psychological aspects of child development under the leadership of Dane G. Prugh, M.D., a former pediatric resident and Commonwealth Fund Fellow who joined the department of pediatrics at The Children's Hospital in 1949. We recognized that confinement of the house officers' experience almost entirely to the management of episodes of serious disease in the hospital was poor preparation for pediatric practice, of which emphasis upon health promotion and a continuity of care is a major characteristic. It seemed probable that an appreciation of the development of a group of children in families over a period of several years, of the ordinary manifestations of common diseases in the community, and of the family dynamics affecting relationships and interactions in the home, could best be acquired by assuming direct clinical responsibility for the continuing health care of the children in several families under supervision throughout the whole period of house staff training.

Dr. Robert J. Haggerty, a Cornell medical graduate, who had completed the two-year general practice internship at Rochester and pediatric residency training at The Children's Hospital, was appointed as the Program's first director, and a group of medically indigent families living within three miles of the Hospital (to permit house calls) were recruited. The program of family health care was based on the following principles, which have stood the test of time:

A family focus;

Continuity of care;

Health promotion and illness care by the same team — in home, office, or hospital;

Care by a health team, consisting of a physician, nurse, and social worker.

As soon as the program of training for pediatric house officers was established, it was extended to medical students in their clinical years, with the difference that the students assumed full responsibility under supervision for the care of the whole family, rather than just the children. This meant that the program became interdepartmental, involving faculty members from medicine at the Peter Bent Brigham Hospital, obstetrics and gynecology at the Boston Lying-In Hospital, pediatrics, at The Children's Hospital, and psychiatry at The Children's Hospital and Massachusetts Mental Health Center.

After several years, support from the Commonwealth Fund was replaced by a grant from the U.S. Children's Bureau for "Training and Investigation in Family Medical Practice," and a series of fellows, men and women who had completed their residency training in medicine or pediatrics, joined the program for one or two years. Their training included the provision of family health care, teaching, and research. During a year of study leave in England, Dr. Haggerty became very much impressed with the organization and quality of general practice there. On his return, he began to establish contact with some leading general practitioners in this area, and organized a conference held in Williamstown with the Massachusetts Chapter of the Academy of General Practice on the content of and training for family practice. Since that time several family practitioners have held positions on the teaching staff of the Family Health Care Program, and collaborative research was initiated with a group of practicing physicians. As a result, a number of fellows have come for postgraduate training after some years of active general practice.

With the strong surge of interest among our own students, and the recent nationwide trend toward primary medical care, a residency program aimed at

the training of family practitioners has been developed during the last few years. This involved training in medicine at the Peter Bent Brigham Hospital and in some cases at the New England Deaconess Hospital, in pediatrics at the Children's Hospital Medical Center and in family practice in the Family Health Care Program, with the last year devoted full-time to this activity. This residency program provided for certification in either medicine or pediatrics as well as family medicine, if the candidate spent two of the four years in one or the other specialty, and in family medicine alone if he spent only three years in training.

One other educational activity, which has been a spin-off of the Program, has been the training of social work students in family health problems and of psychiatry residents in normal family dynamics. And now Dean Goldhaber of the School of Dental Medicine would like to see his students participating in this Program as members of the health team.

Results

What have been the results of the 20 year operation of the Family Health Care Program at the Harvard Medical School in facilities provided by the Children's Hospital Medical Center? During this time most of its support has come from grants from the federal government after its initiation by the Commonwealth Fund, with a supplement from the Charles H. Hood Dairy Foundation, but this has been further supplemented by income from patient care, and, in the past two years, by income from an endowment donated to the Harvard Medical School for family medicine by the trustees of the Theodore Schulze Fund.

House Officers in Pediatrics

Dr. Haggerty gave a detailed description of the program and attempted an evaluation of its early years of house officer training and medical student education in an article published in 1962.¹ The majority of pediatric house officers found the experience valuable, particularly after they had entered practice, in teaching growth and development, the socio-economic and emotional factors in health and illness, the management of common problems and the value of preventive medicine in

practice. Unfortunately, as the Hospital grew increasingly busy, and the Program had to move its headquarters to a building three blocks away, it became increasingly difficult to get them to break away from their hospital activities to attend to patients at the office or in their homes, and the program for house officers has been dropped. However, we are trying to structure a primary health care experience for house officers in the Hospital proper. One thing was clear; the conscientiousness with which a house officer met his commitments to his patients personally, rather than through a substitute, was a good indication of his or her suitability for practice.

Medical Students

In the first few years, a group of third and fourth year students were assigned arbitrarily to the Family Health Care Program with matched controls to test whether or not it taught them greater social awareness. The results of that experiment were not convincing, but we did learn that the teaching program went much more smoothly when it was made an elective course. We have never felt that this type of experience — direct responsibility for the complete health and medical care of several families over most of the last two years of medical school — was desirable for every student in an institution with as varied a student body as Harvard, but only that it should be available to those who want it. In 1960, 64 of 129 third year students volunteered for this course, of whom less than half could be accepted. At present 16 third year students are enrolled, with 18 fourth year students in the Program for a second year. Curriculum changes have made for some difficulties in organization, but there remains a healthy interest in the Program by students, (some are headed for family practice, while others are not), who desire to explore this aspect of health care delivery by clinical experience and seminar teaching.

A few anecdotes from the longitudinal course in family health care will serve to indicate better than generalizations the nature of this medical student experience. One fourth year student, who wished to become a surgeon, was called by his family in the midst of internship examinations for the Boston hospitals because one of the children

had what sounded like gastroenteritis. In the midst of this stressful, busy period, he managed to find time to make a home visit, and, on examining the child, made a tentative diagnosis of appendicitis, and arranged by phone with his staff supervisor to have the child seen and admitted for operation, which proved his diagnosis to be correct.

In another instance, a student making a home visit on a mother and her new baby two weeks after delivery, made a diagnosis of acute post-partem psychosis, and, with the backing of the staff psychiatrist, was able to bring that patient through this episode without hospitalization; this would not otherwise have been picked up until a six weeks obstetrical check-up, when she was nearly well. Such episodes do not occur frequently in any practice, but are shared with other students in the group at regular seminars held after health clinic sessions.

In 1971, Alpert, Kosa, Rosenblatt, and Feinbloom² studied the long-range effects of the longitudinal course for medical students by a mail questionnaire. Of 894 students enrolled between 1957 and 1970 inclusive, 83 percent replied. Their conclusion, from looking at ultimate career choices, was that during the period when students took family health care as an elective course, it principally attracted students who were looking for reinforcement of their career choices. Family Medicine was the most important undergraduate clinical experience for only 4.6 percent of those students enrolled in the compulsory course, but for 15.2 percent of the students in the elective course from 1966-70.

With a new federal grant, it has been possible for the Program to offer students the opportunity to spend an elective month with a family physician preceptor, practicing in Needham, Amesbury, or Gardner, Massachusetts, or Antrim, New Hampshire, a rural community. This has proved increasingly popular, and ten students have signed up for the first six months of the coming academic year.

In addition, the Family Health Care Program offers a group of from 16 to 20 students in the first year class an opportunity to observe growth and development, family dynamics, and the socio-

economic aspects of health care delivery as one alternative in the introductory course in behavioral science. At the other end of the spectrum, the Program staff have been able to advise students interested in careers in family practice about suitable programs of residency training. Since 20 percent of the medical students graduating in 1974 from American medical schools have applied for this type of training, and an increasing but lower percentage of Harvard students are heading towards careers in primary care, this is an important service.

Fellows

Since inauguration of the fellowship program in 1960, 43 men and women have been trained. Of these, 19 are in full-time primary medical practice, as pediatricians, internists, or family physicians, but the majority are also doing part-time teaching. Of the 23 in full-time positions, the statistics given in Table 1 should be of interest in indicating their diversity of background and career choices.

Table 1
Full-Time Physicians
Trained as Fellows

<i>Previous Experience:</i>	
General Practice	3
Family Practice Residency	3
Pediatric Residency	14
Medical Residency	3
<i>Current Activities:</i>	
A. Full-time Teaching	
Family Practice	7
Ambulatory Pediatrics	8
Public Health	2
Community Hospital	2
B. Public Service & Administration	3

Thus, virtually every physician who has been trained, except for three in practice in rural areas and three persons in public service, is engaged in full or part-time teaching of house officers or medical students in the broad field of ambulatory and primary care. Eight are directors of Family Practice or Primary Care Programs, six in association with medical schools, while four are directors of Pediatric Out-Patient Departments in different medical schools. Thus, they are contributing significantly to the need for properly qualified teachers in family practice, ambulatory and primary care programs.

In addition, fellows have contributed significantly to the teaching of Harvard medical students during their training period and to many of the research projects, which have been an important part of the attention which the Family Health Care Program has drawn to the problems of family medicine. These have covered a wide range of subjects — from streptococcal infections in families, home accidents, and the reaction of middle-class physicians to patients of another social and cultural group, to the utilization of out-patient and emergency facilities by indigent families. The Program, through its Medical Care Research Unit headed by the late John Kosa, Ph.D., a medical sociologist, carried out a major controlled experiment over a three-year period, with support from the Commonwealth Fund and the Children's Bureau, to determine the impact of care by the Family Health team upon the health and pattern of utilization of health and medical care facilities of urban indigent families. The results will be published shortly.³

Family Practice Residents

During the past few years the first year fellows have been principally those enrolled in the final year of the residency program. They have been more heavily engaged in care, carrying a case load of 150 families each, with time for teaching, but somewhat less time for research. This program will be discontinued, but we hope it may be re-inaugurated in conjunction with one or more community hospitals which are interested in developing such training. Those few who have completed their training have gone into family practice in most cases.

Staff

The strength of the Program lies in the continuity of its staff. Two former directors, Dr. Haggerty and Dr. Alpert, have become professors of pediatrics at Rochester and Boston University respectively. The third director, Dr. Richard Feinbloom, has given splendid leadership in a very difficult transition period. The chief public health nurse, Miss Ellinore Lenehan, and the chief social worker, Miss Dorothea Chicker-ing, have both been with the Program since fairly early days and have given it great stability. Tribute could be paid to many of their assistants and clerical

help who have been exceedingly loyal, while the families, who have been served by the Program, who are now represented on an Advisory Council, deserve a lot of the credit for its success. Continuity is difficult in a training program in which the physician members of the health team change every one to three years, but the nurse and social worker, as well as the director, have provided the essential continuity that is so important to the patients.

Summary

The Family Health Care Program has provided expanding opportunities over a twenty-year period for those Harvard medical students who desire to obtain first-hand experience in family medical practice and to learn about family medicine. It has provided teachers and leaders in family medicine, primary and ambulatory care to other hospitals and medical schools. And finally, it has provided a field laboratory for the study of family health problems and health and illness in the community. Although Harvard, with its highly sophisticated teaching hospitals, will probably always lean heavily towards the training of specialists even for primary care roles, we believe that just because it is the kind of medical school it is, with a varied and talented undergraduate and postgraduate student body, the field of family medicine needs to be represented in its educational offerings at both the undergraduate and postgraduate levels. We foresee a continuing role for the Family Health Care Program, in providing a natural focus for the rising interest of medical students in family medicine and for the post residency training of fellows to serve as future teachers in this field.

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Primary Care Internal Medicine Training

by Richard N. Winickoff, M.D.

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The social mandate and government support for scientific and technological efforts in medicine over the past 20 years resulted in extraordinary advances. At the same time, there was a parallel decline in interest in careers in primary care among medical students and young physicians. As general practitioners died or left general practice to become specialists, they were not replaced. The average citizen was confronted with the familiar paradox: unsurpassed medical care available in the hospital, but no one to turn to when feeling ill. It is not surprising that the emergency room, that gateway to medical salvation, was inundated with all manner of common, non-emergent problems. But the situation is changing. The new social mandate is clearly the provision of primary care — now perceived to be the major unmet health need of our citizens. And though the problems have not yet been solved, the atmosphere is right for their solution.

Several Harvard institutions have been developing training programs for primary care physicians. At the Massachusetts General Hospital, two interns in medicine have spent six months of this year learning ambulatory care in a new program. At the same time, the Harvard Community Health Plan (HCHP), aided by a planning grant from the Robert Wood Johnson Foundation, has provided the ambulatory half of a new type of medical residency at the Beth Israel Hospital (BIH) and Peter Bent Brigham Hospital (PBBH). Four residents have participated in the collaborative program this year.

The planners of these programs recognize that many internists are already providing primary care to adults and spending much of their time seeing ambulatory patients with complaints ranging from sore throat to chest pain. Although internists have always given primary care, they have played an increasingly important role as a result of

the decline in numbers of general practitioners. The idea of providing total care for the adult patient attracts many people to the field of internal medicine. Unfortunately, current training programs in internal medicine place no emphasis on the major component of primary care: ambulatory care. There are special skills required to manage such chronic illnesses as angina, diabetes, and arthritis in outpatients, and one clinic session per week is inadequate to learn them. The care of such common conditions as acne, low back pain, and prostatitis is given by specialists in most teaching hospitals, so that the hospital-trained internist lacks the ability to handle these problems skillfully when he first confronts them in his practice. In addition, many of the issues of ambulatory medicine are different from those of hospital medicine. For example, how is it possible to deal most effectively with the difficult problems of obesity, smoking, and alcoholism before they result in irreparable damage? Why do some patients with serious chronic problems miss their appointments, while other, basically well people come in every time they have a cold? How does one gain the trust of patients so that they will adhere to a beautifully planned therapeutic program, rather than ignore it?

The program at the Harvard Community Health Plan has attempted to overcome some of the shortcomings of traditional programs by providing intensive experience in ambulatory internal medicine, special training in ambulatory care of common conditions outside of traditional internal medicine, and conferences dealing with the care of ambulatory patients and the organization of health care services. The training program began in July 1973, with four residents, two from the PBBH and two from the BIH. They rotate in approximately two-month blocks between the hospital and the HCHP ambulatory

center at Kenmore Square. At any time, there is one resident from each hospital assigned to HCHP and one assigned to the hospital. The resident assigned to the hospital continues to have at least one and sometimes two primary practice sessions so that he can provide continuing care for patients.

During the HCHP rotation, the resident sees new patients and develops a practice under the supervision of a staff internist. Time is allotted in the schedules of both for review and discussion of patients. The resident is assigned to one of four internal medicine areas and becomes part of a health care team. He works closely with one nurse who shares the primary care duties for his patients. Patients see a physician for an initial health assessment, and the patient's ongoing problems are discussed with the nurse. The nurse is frequently the first contact for the patient when acute problems arise, and she may herself treat common problems according to protocols. By working in a system where the nurse has considerable patient care responsibility and does some of the tasks traditionally restricted to the physician, the resident learns to work as part of a team. The resident has four internal medicine sessions (half days) per week during his ambulatory experience, and he also participates in coverage of HCHP patients at night. When on at night, he and the supervising staff internist discuss all calls and see patients together. For the first time, the resident participates in decisions regarding hospitalization from the point of view of the responsible primary physician rather than from the point of view of the harried emergency room or ward house officer, and his perspective is broadened. He is also introduced to the difficult task of evaluating patient complaints over the phone.

The training in specialties outside of internal medicine has consisted largely of seeing patients referred by HCHP internists to various specialties there. Dermatology, orthopedics, gynecology, allergy, neurology, otolaryngology, surgery, and ophthalmology have all been offered. The emphasis in these sessions is on expanding the ability of the trainee to handle common conditions skillfully. But because all patients are referred, they come with one or another feature that makes them a diagnostic or management problem.

The opportunity to see these patients with the consulting specialist helps the resident understand which problems he can handle on his own and which he should refer, an important lesson for the future primary care physician. Specialties have also been offered at the BIH, PBBH, and Massachusetts Eye and Ear Infirmary. As the year has progressed, the residents have become valued consultants to the staff internists for problems in specialty areas. Many staff internists wish they had had the kind of broad-based training that the residents are receiving. Practical experience in ambulatory internal medicine and specialties is supplemented by a full complement of conferences. There are formal case presentations, didactic sessions, and a radiology teaching conference at HCHP. Ambulatory care journal clubs at both the BIH and PBBH deal with common conditions such as headache and constipation, and general topics such as drug compliance and screening. In these forums, an attempt is made to use the medical literature in a scholarly manner to focus on problems presented by patients in the ambulatory setting. An evening seminar series invites guest speakers to discuss health care issues. The programs this year included the crisis in primary care, paramedical personnel, Professional Standards Review Organizations (PSRO's) and the current status of legislation for national health insurance.

A group psychiatric session became the highlight of the week for residents as well as staff participants. Run by a psychiatrist and an internist as co-leaders, it consisted of the two residents assigned to HCHP (often the residents assigned to the hospitals also made a special effort to attend), three other staff internists, a psychiatric resident, an internal medicine nurse, and a psychiatric nurse. Initially focusing exclusively on case presentations of problem patients, the group was progressively able to share personal feelings that arose in the care of patients. Major themes included death, relating to consultants, nurse-physician and physician-physician interaction, sexuality and sexism, and intimacy versus distance in dealing with patients. None of these topics was dealt with didactically, but all came up in discussing day-to-day professional experiences, and the participants unanimously felt that the group helped them both to handle the

clinical problems of their patients and to understand themselves.

The problems of the program fall into two broad areas: integrating a teaching program into a service organization (HCHP), and providing a unified program at different sites (hospital and ambulatory center) where two different styles of medicine are practiced. Although other residents from the BIH and PBBH had been seeing patients previously at HCHP for one session weekly, once residents came to spend all of their time with us for two-month periods, a full-scale teaching program and an academic atmosphere both had to be developed. Conferences and rounds have been added one by one throughout the year as residents felt the need for more teaching. The psychiatry seminar began in September; radiology conferences in October. In December, weekly visit rounds were added to preceptor sessions as an additional forum to discuss internal medicine problems. A monthly combined rounds with the obstetrics-gynecology service started in January. Preceptor schedules had to be rearranged so that there would be more time available for communication. Next year, there will be further adjustments in the way supervision and teaching are provided during internal medicine sessions.

Another aspect of the addition of residents was that patients of HCHP had to be informed of the residency and given the choice of whether to participate as residents' patients. The professional staff, both physicians and nurses, had to accept the residents and integrate them smoothly into the service program. As a result of these problems, keeping residents' schedules full was a problem for many months. Through education in the patient newsletter and by personal communication with the staff and patients, this problem has been largely overcome.

Despite difficulties, there are certain advantages to teaching residents in a setting that provides comprehensive care to a cross-section of people. Unlike the outpatient departments of hospitals which concentrate the very old, the very sick, and the socially downtrodden who slip through the interstices of the private health care system, HCHP cares for a varied popula-

tion made up largely of working people, but including a number of low-income and welfare patients as well. Psychological problems masked as somatic complaints are frequent. These issues arise in everyday practice and are not crowded out by the necessity to deal with overwhelming end-stage disease, something that is done more intensively in the hospital part of the training program.

The second major problem area — creating a unified program from two traditionally disparate elements, ambulatory and hospital medicine — surfaced in several ways. Early in the year, and to some extent throughout, the residents were distressed by the relative lack of “pathology” in the patients they were seeing. This complaint undoubtedly reflects the disease-orientation of their previous medical school and internship experience. It also reflects the relative youth of the HCHP patient population as well as the fact that all patients are encouraged to come in for initial health assessments, whether or not they have complaints at the time. Next year, a special effort will be made to do some selection of patients with significant medical problems for the residents. The fact that there were two distinct and separate parts of the program also meant that the residents had to become accustomed to two sets of people, and two organizational hierarchies, and in a sense they had to “prove themselves” in two places; and being in a new program and in each place only six months, it was especially hard. In the hospital they did the same rotations but often left twice a week for “clinic” rather than the usual once. At HCHP, though they were seeing patients, they were “residents” and, hence, different from staff internists. The residents were not the only ones who felt frustrated by the separation of the two aspects of the program; those responsible for training in both settings met frustrations in scheduling, providing leadership for the residents, having input into the other side of the program, and developing a unified curriculum. Clearly, coordination and integration of the two aspects of the program must be improved.

In solving the problems of developing a training program within a first-rate ambulatory care setting and integrating hospital and ambulatory segments of

training, we will be overcoming major obstacles to the development of primary care physicians.

In order to monitor the effectiveness of the program to prepare physicians for careers in primary care, an evaluation program will be introduced in July 1974. Under the supervision of the Harvard Center for Community Health and Medical Care, this program will seek to characterize trainees from the point of application for the residency, chart their progress in training, and continue to acquire information from graduates well into their careers. Some of the following types of data will be collected:

1. Sociodemographic indices, e.g., age, sex.
2. Previous training, e.g., undergraduate education, medical school.
3. Previous professional experience (in and out of medicine).
4. Attitudes toward the organization, teaching, and delivery of primary care.
5. Expectations of the training program and of a career in the teaching or delivering of primary care.

One of the purposes of the evaluation will be to improve selection of individuals who will continue in careers in primary care.

A further development in the program for next year is the involvement of the Harvard School of Public Health in planning and teaching a course based on the experience of the evening seminar series in health care issues. The course will run for two years and have two separate components. The first component is health services administration. In this area, the health care delivery system in this country will be studied. Topics covered will include the history of health legislation, the effect of economic, technological, professional and political influences on the health care system, and then specific aspects of the system such as payment mechanisms, styles of practice (solo, group, neighborhood health centers), health maintenance organizations, paraprofessionals, and regulatory agencies. The format for the seminar

will be a one-hour lecture by a member of the faculty or an invited guest, followed by a discussion led by a member of the seminar group. Readings will be provided to the participants prior to the meeting. The second component of the course will focus on clinical epidemiology and preventive medicine. Major public health problems in which intervention can have a preventive impact will be discussed. Some of these include smoking, obesity, and hypertension. In addition to presenting evidence that there are risk factors in a variety of diseases, the course will examine evidence that intervention can alter these factors, and where possible, approaches to therapy and behavior alteration will be presented. In addition, the whole area of cost-effectiveness in screening will be scrutinized critically.

The Beth Israel Ambulatory Center (BIAC) will serve as an additional training site starting in July 1974. This reorganized Outpatient Department combines parts of the previously separate general medical, pediatrics, obstetrics-gynecology, and psychiatry clinics into a unified primary care center. The two residents who will enter the BIH program this year will have their ambulatory internal medicine experience in BIAC over the next two years. Specialty experience will be primarily at the BIH, but the other participating institutions will make specialty experiences available where appropriate. The problem of unifying the hospital and ambulatory parts of the program may not be as difficult where both segments are under the same roof, but that remains to be seen. Beginning in July 1975 the group will have their two-year ambulatory experience at HCHP. The PBBH will have three new junior residents in the program, all of whom will have the majority of their ambulatory experience at HCHP. However, the Harvard University Health Services, a comprehensive care facility for members of the Harvard community in Cambridge, will serve as an important additional training site. The possibility of expanding the program to include training of pediatricians and obstetrician-gynecologists with a particular interest in primary care is being explored.

This program is a multi-institutional cooperative effort to train people who can play a major role in responding to

the health care needs of our society. It is an important goal of the program not only to produce well-trained practitioners, but to produce leaders in education and research in primary care. Recognizing the importance of the participation of the Harvard Medical School in making primary care a strong discipline and an attractive career for medical students, the Robert Wood Johnson Foundation is funding the expansion of

the primary care residency program into other Harvard institutions. Under the new grant, existing programs in internal medicine will train more people, and other departments, such as pediatrics and obstetrics-gynecology, will examine the feasibility of training primary care practitioners, also. If people are to ultimately have accessible, high quality primary care services, this program and others like it will have to succeed.

The Primary Care Program From Idea . . .

by Stephen E. Goldfinger, M.D.

Associate Professor of Medicine at the MGH

Rarely, an intuition is completely fulfilled at the moment of its perception. Technicalities regarding its staging become incidental as the image assumes a compelling reality of its own. A heady way to start, perhaps — but no other introduction quite describes what happened when Alan Goroll '73, in the early part of his fourth year, suggested a primary adult care training program for the MGH. To me, it virtually existed by the time he completed the second sentence. A few details needed some filling in, perhaps, but the training slots would be unmistakably available in eight months!

Alexander Leaf required no convincing, for when Alan's idea was related to him, our Chief of Medicine merely nodded, "Speak to Charlie." The mere nod from Alex was more than mere. It meant that impulse had withstood the challenge of an extremely rational mind. Dr. Charles Sanders, the hospital's then newly appointed General Director, also recognized the value of Alan's proposal. He quickly endorsed the development of the program and supported it before the General Executive Committee. His only admonition revealed his characteristic prescience: "Whatever else you do, make certain that every effort is made to try to secure the funding it will need." And this was a full year before Phase 4!

The events that flowed thereafter happened too quickly — in fact, too easily — to have any special meaning of their own. A planning committee was formed and in short time, adopted the princi-

ples and devised the strategies that would be needed. Among them were the following:

1. The primary care interns would not be second class citizens at the MGH. Accordingly, their selection would be based on the same criteria of scholastic excellence, integrity, and maturity as existed for our traditional medical interns. To further insure equity, their hospital assignments, although reduced in magnitude because of ambulatory care rotations, would be precisely those of the traditional training program. The slots they occupied would be the respected and demanding ones that feature heavy responsibility.

2. Half of their training would be devoted to ambulatory care, and would begin in the *first* year. To delay this exposure would risk achieving their desired recognition as primary caretakers. Also, an initial year spent fully on the in-patient services might prove too seductive for even the most highly motivated candidates. After a few intensive care rotations, the Lazarus complex is especially potent. Preventative medicine and chronic disease management just cannot compete with the excitement of successful "catastrophology."

3. The program would probably stand or fall on the success of its ambulatory component. Thus, the major effort was to make this part of it an exciting learning experience. To accomplish this, it would be necessary to:

- a. Develop the opportunity for group dynamics within the ambulatory care setting. A Primary Care Team, comprised of the interns, their nurse-practitioner, social worker, and senior physician, was devised to serve this end.

- b. Prevent the pressures of excessive service demands from interfering with stipulated educational goals. The schedule was created to include visit rounds, team rounds, and informal learning encounters — with sufficient time set aside for all of these to occur in as predictable a manner as they do on the hospital floors.

- c. Acquire relevant skills that reach beyond those of the traditional internist. In particular, it seemed important for the primary care physician to identify and manage many routine problems that are customarily referred to specialists. Accordingly, arrangements were made for extensive, supervised instruction in office gynecology, orthopedics, dermatology, psychiatry, ophthalmology, etc., enlisting outstanding teachers to represent each specialty.

There was a brisk acceleration of the planning phase when Alan and Terry O'Malley (Cornell 1973) were selected to be the first two interns in the Primary Adult Care Training Program. Even before their graduation from medical school, they were sharing their thoughts and in essence, refining the curriculum to correspond to their needs and aspirations. By the time they put on white uniforms in late June, the program was clearly laid out on paper. By the time they hit every slot on the schedule during the year, the space, the patients, and the teachers were waiting for them. In particular, the teaching experiences that were integrated into the ambulatory care rotations were regarded as outstanding.

A recent visitor to our Primary Care Unit asked how many years it took to set up the program. When informed that the time frame was eight months, he gasped and asked how it was possible. I can think of several very important factors. The first is Dr. John Stoeckle '48 who directs our Medical Clinic. His role was much more important than mine, for he undertook the responsibility of developing the ambulatory care track. Because John established the Primary

Care Team, the various teaching strategies, the sub-specialty rotations, and the overall ambience of the most vital part of the program, its success is largely due to him. (And he'd probably talk more about hard work than intuitions if asked about how things got started.)

The efforts of Alan and Terry must also be recognized, for they helped to structure their program in a manner that has never been asked of others who are invited to become medical interns at the MGH.

Then there is the hospital itself. I often think that this is the main reason why the program seemed destined to succeed from the moment of first utterance. For the MGH is an institution dedicated to total patient care. Its reputation as a referral center and a research empire seems incompatible with this, and many outsiders find it hard to believe. But there is a vast amount of personal, comprehensive, and continued care provided to local residents who regard the hospital as their principal or only health resource. Teaching rounds on the Bulfinch are as apt to feature discussions of the psychological impact of a myocardial infarction as of enzyme kinetics. There is more attention given to planning efficient workshops of low morbidity risk than to hormone receptor sites. Attending physicians are most valued for their clinical judgment and personal concern for patients. A number practice as primary caretakers.

In brief, the sentiment for the program was clearly present. And there was no serious philosophical opposition to the potentially threatening premise that henceforth, the dimensions of a medical teaching service could not be expressed in terms of beds alone. The new equation had to allow for that long string of examining rooms at the geographical periphery of the hospital. The challenge was to convert this front line from defense to offense. In this regard, the training program served as an important agent of change in its own right, for it sparked a series of rapid organizational, architectural, and pedagogical improvements in the medical clinic which has already had a positive influence on patient care.

What lies ahead? Certainly there will be an expansion in numbers as two new

primary care interns begin late this month. It is anticipated that the internship group will increase to four in 1975. The second year of the program is about to be tested. It was designed to be a natural extension of the internship year. In addition to the completion of specialty rotations, the ambulatory care schedule will include assignments to MGH affiliated neighborhood health centers in Charlestown and Chelsea. The latter will provide a heightened awareness of newer approaches (and hopefully some solutions) to community health problems.

The MGH program is among the beneficiaries of a recent grant from the Robert Wood Johnson Foundation to

To Reality in eight short months by Alan Goroll '73 Primary Care Intern, MGH

If you were graduating from medical school in the early 1970's and wanted to train for a career in primary care, your options were limited. There were rotating internships (left over from the GP days) or programs in Family Medicine. If you were interested in internal medicine as well as primary care, then you usually took a traditional medical internship and residency, and had to delay your training in primary care for two more years.

Facing this unsatisfactory situation, I started thinking about alternatives. It occurred to me that one could make a strong case for combining training in primary care with the traditional experience in medicine. After all, doesn't the practice of internal medicine involve ambulatory care as well as inpatient management, chronic as well as acute care? Moreover, as pointed out in recent studies, practicing internists function more as primary caretakers than as referral physicians. Therefore, if one wanted to train internists who will be involved in primary care, it seems only logical that one would include a rigorous experience in out of hospital care as well as the traditional work in crisis medicine. In addition, there are many

HMS for the development and support of primary care training positions at its major teaching hospitals. Although each program will maintain its unique features, there will also be shared activities, such as a series of seminars in epidemiology and health care delivery presented by faculty members of the Harvard School of Public Health.

Ultimately, a formal evaluation of the training programs will be required. Although its precise form has not yet been designed, one can only hope that it will be sufficiently penetrating to determine not only the influence of HMS on primary care training, but also the impact of primary care training programs on HMS.

common minor psychiatric, orthopedic, gynecological, ENT, and dermatologic problems which the internist frequently sees in his practice. Due to a lack of training, he often refers these problems, although they probably could and should be handled by him. A training program in primary care might also include some instruction in these non-medical subspecialties, geared towards handling the minor problems in these areas encountered in the daily practice of medicine.

With these thoughts in mind, I approached people in the department of medicine at the Massachusetts General Hospital and within less than a year the program was a reality. At first glance, it might seem strange to take a proposal for primary care training to the MGH, but on closer examination the reasons are substantial. In the first place, the hospital functions as primary caretaker to over 80 percent of its patients. Tens of thousands of people use its clinics. These are by no means exclusively people with rare, reportable diseases; for the most part, they have the typical medical problems seen in any urban center. Often these people are quite ill, providing challenges in their ambula-

tory management. Second, the hospital's teaching resources are enormous. Third, the medical outpatient services are undergoing far-reaching re-organization and should become a model for ambulatory care. Finally, the ward medicine is second to none, which is particularly important if the amount of time spent on inpatient medicine is going to be decreased. Thus the Primary Care Adult Medicine Program was established at the Massachusetts General Hospital.

The Primary Care Program begins in the internship year with three months of inpatient medicine (same standard rotations since the Primary Care interns are part of the regular medical house staff) followed by six months in the outpatient and emergency ward setting, followed by three more months of inpatient work. The assistant residency year is also six months inpatient, six months ambulatory work. During the outpatient segment, there is one session each per week in orthopedics, dermatology, office gynecology, and psychiatry. The remainder of the time is spent in the Primary Care Unit, an experimental teaching section of the medical clinics that was set up for this program. There are two interns in the Program this year; Dr. Terry O'Malley, a graduate of Cornell, and myself.

The Primary Care Unit is composed of the two interns, a nurse-practitioner, staff nurse, social worker and staff internist. The house staff, nurse-practitioner and social worker function as a team in delivering patient care, with much of the daily patient management provided by the nurse-practitioner and social worker. This is especially true when the interns are on the wards. Visit and work rounds are key parts of the Primary Care Unit day; time has been set aside for indepth review of cases by the team and its visiting physicians. Preventative and psychosocial issues as well as a rigorous review of medical problems are undertaken. Subspecialty work is done in each of the subspecialty clinics, with the Primary Care interns seeing patients under supervision of senior staff. The remainder of time is spent in the Emergency Ward and the Ambulatory Screening Clinic, a walk-in medical clinic. Patients to be followed in the Primary Care Unit are derived from all of these practice sites as well as the

traditional sources. For example, a patient seen in gynecology for an IUD, who is found to be anemic and hypertensive, will be followed in the Primary Care Unit.

Not all work is done at the MGH. To get a feeling for how a community HMO works, there are two weeks at the Matthew Thornton Health Plan in Nashua, N.H. This is a progressive community health center, well known for its effective use of paramedical personnel, problem oriented record keeping, and excellent internal medicine.

The first year of this program has been a tremendous experience for both Terry and myself. The support and attention given to making the effort a success has been gratifying. Instead of being tucked off in a corner, the program has been well-integrated into the medical internship and residency, a key factor in making it a first class experience and attracting outstanding candidates for next year. In our opinion, the teaching provided has been the best available, both in medicine and each of the subspecialties; emphasis has been on material and issues pertinent to the practice of primary care. The transition from outpatient to ward medicine went surprisingly well, aided by keeping "tuned" in the EW during the six months of ambulatory care. To be sure, we have treated fewer cases of pulmonary edema (50 vs. 100) and I have not treated a case of cryptococcal meningitis, but I believe the cost will prove

reasonable in exchange for the training obtained in primary care.

Next year there will be two new primary care interns, and four are planned for the following year. The Primary Care Unit will grow and more patient care teams will be established with heavy emphasis on the role of the nurse-practitioner and team practice. We are conducting studies in patient compliance and hypertension and next year we plan to begin peer review and to offer indepth experiences for senior medical students who want to fulfill their concentration requirement in primary care medicine.

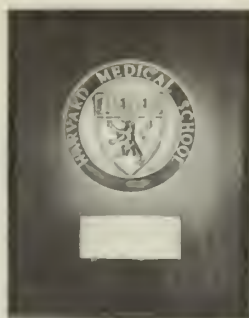
There are certain individuals who were the key to getting this program established, supported, and nurtured. In particular, the encouragement and dedicated work of John D. Stoeckle '48, Stephen E. Goldfinger, M.D., Alexander Leaf, M.D., Charles Sanders, M.D., and Leon Eisenberg, M.D. were instrumental in bringing about the Program. Moreover the support in the subspecialties from Henry Mankin, M.D., Anne Barnes, M.D., Harley Haynes '63, Thomas Fitzpatrick, and Aaron Lazare, M.D. could not have been more enthusiastic. Grant support was provided by the Robert Wood Johnson Foundation.

In sum, it has been an exciting year made possible by an outstanding group of individuals who were open to a new idea and willing to give it a hearty try.



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The Dollar Impact on New Directions in Medical Education and Practice

by Margaret E. Mahoney

Vice President, Robert Wood Johnson Foundation

When I first began to think about the general mandate to concern myself with the question of what financial incentives do to influence the direction of medical education and practice, I tentatively titled my working document "Money Matters in Medical Education." I thought that this would be a device to keep my mind on the target, and besides I liked the alliteration. I immediately found, however, that my mind was sidetracked by the words themselves, that by changing "matters" from a noun to a verb I had a declarative sentence, and by indulging in an oral exercise I declared what indeed I believe, "money does matter," in our society.

In financing medical education there are certain specific categories for which support is sought. The most important encompasses what is best described as the major academic objectives or the educational and public service obligations of medical schools. The general category covers the general costs related to the teaching and caring functions, and the four primary money sources are state and local government appropriations or subsidies, professional (medical service plan) income, indirect cost recovery, and tuition and fees — plus some minor miscellaneous revenues. Federal government input is relatively small for general support, running roughly five to eighteen percent for each school.

In 1972 the greatest support for general operations came from state government appropriations. The second largest source of operating revenue was from professional fees or medical service plan income — funds derived in part from fees charged by full-time clinical faculty members for patient care.

Recovery of indirect costs to defray overhead expenses in administering grants and contracts ranks third as an income source for general operations, providing 14 percent of the total general operating revenue for the schools. The fourth significant source is tuition and fees, accounting for ten percent of total general operating support and rising from \$63.3 million in the previous year to \$78.5 million in 1972.

A second large category for which support is sought by medical schools is the purely service oriented side as distinguished from the purely academic objectives. The federal government has shown an increasing interest here through specific programming such as the Regional Medical Program and other service grants and contracts. The growth and support for such activities has undoubtedly led to the increasing interest of medical schools in operating health services.

The Influence on Training

The training of physicians following the award of the M.D. degree is the period of final preparation to practice. It is financed through various sources. The federal government's contribution is indirect but most significant, and is not easily understood. For example, several agencies, such as the Department of Defense and the Veterans Administration, have supported physician training because of their need for manpower to staff their own health facilities. But for the last ten years the major input came from the National Institutes of Health (NIH) through its system of training and fellowship awards. How that is now threatened is discussed later.

No one, however, can get a true picture of financing the training of health manpower until we understand more about the impact of Medicare and Medicaid — and the facts do not exist. What we know is simply this: None of the outlays go directly for training, but under Medicare reimbursement for hospital care includes salaries of interns and residents of the hospital staff. Teaching done by attending physicians is also reimbursable as an institutional cost to the hospital.

While the outlays for research training have declined both absolutely and relatively, from 26 percent of the total in 1969 to the anticipated 13 percent estimated for 1974, the increases over the same period for training practicing physicians and dentists are predicted to be sustained through 1974. But, if the changes proposed for the President's 1974 budget are carried out, 1973 will represent a high watermark in federal support for the training of many health professionals with, for example, the research training programs being phased out. The new goal in the President's budget is three-fold: To increase the numbers of people in the health professions; to improve the geographic and specialty distribution of health manpower; and to insure the health profession schools a financial base that allows expansion while maintaining or improving educational quality.

* Miss Mahoney's article is based on the paper she delivered as part of the "Medicine and Society Forum," Harvard Medical School, Boston, Massachusetts, December 4, 1973

Parallel to this federal interest in improving the distribution of health manpower has been an increased federal concern with the relationship between medical care costs and the maldistribution of health manpower. One outcome of this interest has been an increased interest in training new kinds of personnel who supposedly will supplement the more expensive physician, dentist, and nurse.

In 1971 we began to see the impact of this new federal direction on medical education. The Comprehensive Health Manpower Training Act in that year specified basic institutional support in a substantial amount but it changed from the earlier "formula" grants to capitation payments, encouraging schools to increase enrollments and reduce the number of years to graduation.*

Two kinds of federal assistance are available to students — loans and scholarships. What is surprising is that the percentage of students receiving federal loans has declined nationally from 37 percent in 1967 to 29 percent in 1972, while the percentage receiving scholarships has increased. The school must put up \$1.00 of its own money for every \$9.00 of federal money; it then receives a share of the loan appropriation for that year in proportion to its share of the total enrollment of eligible schools. Additionally, the government will forgive or repay 85 percent of any outstanding loan for a student who agrees to practice in a shortage area for three years.

* To qualify, schools must increase their first year enrollment by a specific percentage and agree to undertake projects in at least three of nine areas including a shortened curriculum, training new kinds of supplementary manpower, educating more primary care physicians, and assisting disadvantaged persons. Schools received a basic amount for each student, a higher amount for each graduate, and a bonus for students in classes that exceed the required increased enrollment by five percent — or five students, whichever is larger. A four-year school of medicine is eligible for a basic grant of up to \$2500 per student below the senior year, \$4000 per graduate, and \$1000 additional per enrollment bonus student. Three-year schools receive \$6000 for each graduate. Schools can also receive up to \$1000 for each student in a physician assistant program.

Students who agree to practice general medicine in a shortage area may receive a scholarship of up to \$5,000 per year for each year of service. For the first time the act authorizes loans and scholarships for U.S. citizens studying at foreign medical schools.

Thus, in summary, special programs under the 1971 Manpower Act are aimed at affecting change in utilization, and efficiency of health personnel. In turn, the health services system is also affected. It is too early to estimate the impact except to say that one influence, which grows out of a major goal of the recent HEW outlays, has been to increase the actual numbers of health personnel. The numbers of physician graduates increased from year to year by less than one percent from 1956 to 1966 — compared to a four percent annual growth rate from 1966 to 1972. We went from a ratio of 144 physicians per 100,000 population in 1960 to 158 in

1970. On the other hand, only 41 M.D.'s per 100,000 population are in primary care.† The bulk therefore are opting for specialty care, and while we believe this group in fact delivers much primary care there is as yet no reliable data to confirm this.‡

Enlarged class size is thus one result of the federal outlays. Also, a number of schools have accepted the challenge of developing a three-year curriculum in order to qualify for the bonus payment under the federal system. No information exists on the extent to which schools have increased enrollment of students who could not afford to attend without financial aid but we do know, for example, that the enrollment of blacks increased from 2.8 percent in 1969 to 6 percent in 1973 — and that many of these students had scholarships and loans.

State support has also had an interesting impact through the states' support for family practice training, especially in southern, mid-western, and far west states. Again, there is no specific information available on the impact but over 140 family practice programs are operational. Another 50 are being developed. However, recent federal cut-backs of support to such programs may inhibit further growth.

† Primary care practitioners are defined to include general practitioners, pediatricians, and internists who provide direct patient care in office-based practices.

‡ The National Center for Health Statistics is carrying out a study on practice patterns to provide such basic data.

The Practice Impact

In the past government funds influenced practice patterns in several ways. The federal rewards, particularly through NIH and the Veterans Administration, undoubtedly encouraged the heavy sub-specialty movement, as well as the choice of where to practice. The high concentration of physicians in urban communities is no surprise since so many physicians elected specialty routes which required or seem to require reasonable access to the technologically-oriented medical centers and to large patient populations.

Furthermore, certain inadequacies in the reimbursement systems for Medicaid and Medicare have discouraged the practice of quality primary care in many communities. The inadequacies of Medicare and Medicaid in this regard are sketched out as follows.

Almost half of the low income people or approximately 16 million Americans are not covered by either Medicaid or Medicare. The irony is that Medicaid has been labeled a program for the poor but it is actually a welfare program, covering only those who are eligible for welfare assistance. Excluded are the working poor, and poor families with no dependent children.

Medicaid coverage benefits vary widely from state to state, because states have considerable control over the types and services offered. Few provide optional services such as drugs, dental care, transportation, home assistance, and prosthesis such as eyeglasses.

Similar limitations exist with the federally financed Medicare program, which does not depend on state participation, but on the aged who are its chief participants. Regardless of income, they are required to pay for part of their care in the form of deductible and coinsurance charges. Less than 40 percent of Medicare's money goes for out-of-hospital direct physician care. Drugs, dental care, preventive services, mental health, transportation, and outreach services are excluded. In general, the combination of a limited range of services and limits on reimbursement prevents any comprehensive health care system, dependent on Medicaid or

Medicare populations, from having any hope of being financially self-sufficient without some underwriting.

The inadequacies of the payment system extend to the middle class. Over 90 percent of Americans under the age of 65 have some private health insurance policy, but sufficient coverage for outpatient or physician-provided ambulatory care and preventive services is still limited. Private health insurance plans have protected primarily against the costs of inpatient surgical care, while the patient bears the burden of out-of-hospital costs for prenatal, general pediatric and medical care, mental health services, and home care needs. The present Administration in Washington and some experts in health insurance believe that high income Americans need only catastrophic insurance, that middle income generally need comprehensive coverage for both in and out-of-hospital care, and that low income Americans need coverage on a non-contributory basis with the funds supplied by the public sector. This was the essence of the draft White House bill.

A parallel problem to the inadequate payment system is the geographic one of where moderate and low income families locate. They are by and large in rural communities and the central cities, areas where it is most difficult to attract physicians. Given the income level of those in rural and inner city areas, it is difficult, if not impossible, to design systems of care that will be financially feasible until we have a national health insurance program that will guarantee a certain basic level of pre-paid care.

Programs designed to give care to those most in need and lacking money to pay for it may look to private philanthropy for covering deficits, but there are problems with this expectation. Private philanthropy represents only a small fraction of what is spent for national health expenditures. Per capita

health expenditures, adjusted for inflation, have been rising at the rate of ten percent a year since 1950, while per capita charitable expenditures in health have been growing at only seven percent a year.

The fact that we have over 13 proposals before Congress to finance health care suggests that there is a recognized need to provide a better payment system for care. These bills also acknowledge the need to cover services for low and middle income Americans. Although there is considerable interest at this moment in launching a national health insurance program, and the White House draft bill has been widely publicized, a truly national program meeting all needs cannot evolve soon. It is an issue of dollars, and while estimates as to when Congress will act vary from as early as 1975 to the mid-1980's, the crux of the decision rests on where the funds will be found to finance a program. Thus, the scale of what is offered will be limited by the money available. The compromise that may be reached would be for employers to shoulder a major part of the costs for those working, but this compromise would provide only part of the money needed.

Influences Affecting the Public Interest

How financial incentives affect the public interest and what safeguards exist to protect that interest are two interlocked questions that can only be considered in the light of the political economy of health. In order to understand the political economy, we have to begin with how government policy is articulated by its spokesmen.

In the present Administration, the stated philosophy assumes that:

1. There are finite resources and the competition for these resources is excessive. For example, how many dollars should go for training versus production of more services?
2. Competition for the limited resources will always be at the margin, and agencies and individuals

must jockey for positions, with one's effectiveness being directly correlated to one's ability to persuasively argue one's case.

3. The issue of decision making on the basis of the opportunity cost, which is the value of the best alternative use of the resources available, is an ever-present consideration.
4. Federal policy should be developed for the public good.

But, who speaks for society? While it is desirable to fix responsibility and to make it obligatory to be publicly accountable, there is in fact no consensus on what constitutes the public interest. There are state groups, congressional committees, citizens organizations, each charged with public interest or self-appointed to protect it. I for one find it difficult to select among them who would be most appropriate to safeguard my interests.

It may well be a matter of values, simply stated as the issue of whether or not science should interact with Congress as the military interacts. Science in the past has done so, and successfully. In the last decade over \$3.5 billion has been spent for medical education, and another \$3.5 billion has probably crossed over into the education side of medicine from the biomedical research side. These expenditures can be directly correlated with the amount of influence that the science sector had in developing national policy. Was this policy in the public interest? Should it be government's responsibility to support medical schools? What are the alternatives?

It may be a matter of politics, as against a matter of values. In one sense, we can say that the political process has played a relatively low profile role in determining national health and science policy because the elective process as it now stands rarely puts people into office who truly reflect the public interests of a district. Political scientists have argued that not until we can reconcile the congressional districts to geographical regions defined for federal funding purposes can we eliminate overlaps and gaps in representation, and fix the responsibility on an elected official for a given population's interests.

Shaping the Future

In what way are financial incentives likely to shape delivery of health care in the future? All indications are that even the limited amount of money beginning to flow from the federal sector will gradually change the mix of training programs, with primary care becoming a true specialty. Changes in the amount and kinds of services, with increased access in shortage areas such as rural and inner city America can be expected; and to a crude extent, a change will begin in the actual distribution of health care personnel, with the expansion of the National Health Service Corps and federal incentives for physicians to join the Corps or other programs aimed at improving care to people now without access.

The best option in the future for shaping delivery of care may be through the regulation of reimbursement policies of third party insurers. The earlier analysis in this paper on the impact of Medicare, Medicaid and other insurance shows that the present inadequacies are directly tied to present reimbursement limitations. In any case, we will not provide a better future in health delivery by further exhortations or by simple tinkering with the system.

The role for the foundations — those few now concerned with medical education and health care delivery — will of necessity be a limited one. In the long run, the major contribution of private philanthropy may be through the preparation of physicians and others trained as analysts who can organize and monitor the system of care. In the short run, foundations can to some degree influence both training patterns and practice settings, but this influence is restricted to developing models which must eventually be tried out on a broad scale through governmental support.

The possibilities of substantially increasing government resources seem

dim until we can forsake the present over-concern with deficit spending and consider the positive aspects of a tax structure that will bring in revenue to meet the expanded need for expanded services in health, education, and other aspects of American life.

A progressive tax system may therefore be the way to generate funds for a health program. Another possible alternative would be a surtax system. These systems should be investigated for their possible impact on improving health care.

Recommendations

There are other steps which we as a nation will have to take to insure a sound approach in medical care. These steps concern the need for establishing a reliable financing mechanism to prepare physicians and other health care personnel, for without the manpower that is properly trained for the job we cannot expect to organize or maintain a reliable system of care.

It seems blatantly obvious to me that the federal government will have to absorb a larger share of the public outlay in training costs.

State support will also have to increase, and such support could be stimulated through federal incentive grants designed to encourage states to supplement federal programs. The distribution of state funds to medical centers by general formula and rewards for good performance seems preferable to line-item budgets and special contracts.

A system for assuring student access to adequate loans seems essential, and consideration should be given to something analagous to a national loan bank.

The real changes demanded are programmatic, however, and these require medical centers to consider how they may discharge their enlarged responsibilities to society and maintain their responsibilities to those they are prepared to teach and to those who are employed to teach. To carry out these enlarged responsibilities, will require a reallocation of funds within these institutions, and in general will require more attention to the issue of costs.

Humility in Planned Change

Planned change requires the development of new concepts, and while programs cost money, money alone is not enough. Neither is it necessarily a matter of new money. It may well be a matter of reallocating existing funds or conserving what exists to do what needs to be done.

Institutions engaged in health care training, biomedical and service research, and the delivery of care are by their very nature complex organizations. To deal with this complexity, they must go beyond mere problem identification and solution. For over half a century they have neglected to deal with the issue of "purpose," and they must rectify this. The consideration of purpose is a process of goal setting, and it can only be accomplished through a planned approach which requires a re-examination of the institution's purpose, and a revamping of the environment to meet the purpose. Such institutions will have to take responsibility in areas where as an institution they have not been active or vocal. They must stand up for quality and diversity; they must speak for social justice; they must encourage constructive change; they must strengthen their governance process; they must learn to make more effective use of their resources.

Just as there are wide differences in career opportunities in medicine, there are wide differences in institutional arrangements which must be considered in order to meet society's needs. The differences should be encouraged, and the uniqueness of some should be preserved. Meharry, Harvard, Chicago Medical have distinct characteristics which make them unlike many of their sister institutions. Such differentiation of institutions should in my opinion be encouraged, to guarantee students who are interested in a medical career alternatives to education and training. There is a range of capabilities and interests among medical school faculties that has provided important input to medical education and training, and holds great promise for the future in patient care. Such a range should be encouraged. There is also increasing recognition that there is equal variety in the

range of needs of patients, and while this adds further complexity to the problem of educating health care personnel and organizing services, it is probably the most significant factor to be kept in mind as institutions consider their purpose and plan for change.

The leadership in medical centers will have to take all of these differences into account, and decide what to accommodate to, in the light of existing resources. The dollars are not likely to increase at the rate needed to accommodate to all of the diversity and demands.

If the leadership cannot be developed from the inside, external forces are bound to be developed which may provoke the necessary change but may also produce internal havoc for the institution. The medical centers ostensibly have the competence to assume the responsibility they need to take for carrying out a proper assessment of the future. Through a coalition of faculty, students, administrators, and trustees they should be in a position to take the kind of initiative that will gain them the respect that has been waning. Schools of medicine and other organizations in our society have overlooked the human dimensions in their institutions and society at large. Caught up in meeting their everyday responsibilities, they have failed to realize that their mission as they conceive it may not suit their constituency — neither students, faculty, staff, or patients. Failure to realize the need to reappraise has led to a failure to communicate.

What is clear is that medical centers are a national resource. It is also clear that they have a major impact on the nature of medical practice, and it is equally clear that there are complicated differences between institutions, and between public and private medical institutions. It is also evident that those going into medicine are entering a very distorted system. I do not know the way out, except to admit the reality, and to begin to deal with it. We must acknowledge that money does indeed matter, that it can be an incentive for positive change, and that certain steps must be taken to assure a brighter future. I have suggested steps, as a way to encourage institutions to think about the direction they want to go. Once the direction is set, I believe that they can find comfortable routes to travel.

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"Dear Ann Landers:"

by Samuel Z. Goldhaber '76

Getting an interview with Ann Landers was more difficult than arranging previous press dates with Nathan Pusey, George Kistiakowsky, and Abba Eban. But Ann Landers has a certain claim that none of these three men, and indeed no columnist in journalism history, can match. She is the most widely syndicated columnist in the world, with more than 800 newspapers running her column and an estimated readership of 54 million people. She states that the closest anyone ever came to matching her was Drew Pearson, with 650 newspapers at his peak in popularity.

Like many successful graduates of Harvard Medical School, Ann Landers has decided to specialize by learning as much as she can about medicine and by helping HMS raise funds. One Harvard administrator lavishes praise on her uncanny ability to fill the University's coffers and points out that she devotes an inordinate amount of time to helping Harvard instead of staying at home in Chicago, throwing parties, and being known as "the hostess with the mostest."

Through her interest in HMS and the 1000 letters she receives daily, she has combined a feeling for where medicine is letting people down and a sophisticated knowledge of psychosomatic illnesses, primary care, and national health insurance issues. Her studies of medical issues and her high level of awareness and common sense have led her to make important suggestions for improving applicant screening, medical school curricula, and postgraduate education.

March 30 was Ann Landers day at the Harvard Club. I had a 45 minute exclusive interview with her, interrupted by a call from the Mayor's office and nervous Harvard Club officials who were doing everything they could to make the day roll smoothly. She was excited because Mayor Kevin White would be presenting her with a specially made Key to the

City. But the \$15 per person charge and the early starting time of 10:30 a.m., distressed her because she knew her audience would be smaller than her liking. Although she anticipated the Mayor's presentation, the afternoon protest of the Gay Liberation Community was not on the day's agenda.

Eppie Lederer (her real name) was born in Sioux City, Iowa and raised in a Jewish home. She was living in Wisconsin during the heyday of Senator Joseph McCarthy and she says was "one of the people who early recognized the pathology of this man." She gathered some of her women friends and told them that a Democratic party had to be built in Republican Wisconsin in order to fight Senator McCarthy. "About 15 women went knocking on doors and talking to people like the Avon ladies would do. We ran the membership up from 17 Democrats to 682. The *New York Times* was amazed. They came to find out what happened." Ann Landers was one of the earliest supporters of William Proxmire and Gaylord Nelson, who are today the U.S. Senators from Wisconsin, and she also backed Patrick Lucey, who is now governor. Local Democrats wanted her to run for Congress in the Ninth District, but she refused.

"When we moved to Chicago, I decided I had to do something with my enormous energy and with my time. But what was I to do? I had no training. I had no credentials. I had no recommendations. I had nothing." One day, while she browsed through the Chicago *Sun-Times*, a column called "Ask Ann Landers" caught her eye. She called an executive of the paper and asked if she could work as an assistant. He told her that Ann Landers had died the previous week but that if she wished, she could enter a competition with 28 other women who wanted the column. Eppie Lederer went to the *Sun-Times* office and picked up copies of the 40 letters she would have to answer. Her dead-

line was three days later. She thought to herself, "I couldn't possibly win it because every one of these other women — all 28 — were professional writers. They had been women's editors, reporters, real journalists, and I was the only amateur among them."

Her first letter was from a woman with a walnut tree which was growing very close to the edge of her neighbor's property. The question was, "Do the walnuts that fall on my neighbor's lawn belong to me or to the lady on whose property they fell?" Lederer thought about the question and came up with a single idea that would prove to be the secret of her column's success — getting expert consultation on all questions where she lacked expertise. "I started to comb my mind for the best lawyer I knew." Finally, she telephoned Supreme Court Justice William O. Douglas, "who had been a friend of mine for years. He said, 'I know you don't drink, Eppie, but what's this all about!' " When she explained, he agreed to look up the legal precedents, and he called her back in half an hour with the answer. The walnuts on the neighbor's property belonged to the neighbor. But she could only cook them or decorate her house with them. She was not allowed to sell them. Lederer quoted the Supreme Court Justice as her source and "naturally, the [*Sun-Times*] judges were amazed at this kind of consulting."

She handled most of the letters similarly and after seven weeks of competition for the column, the publisher of the *Sun-Times* called her and said, "Good morning, Ann Landers."

Not only does she have her high-powered personal consultants, but she also has a complete file of the service agencies in every city that prints her column. She says that Robert Ebert, Dean of the Medical School, has stated that her office provides, "the best service in the world" in terms of referring people to service agencies.

When she is not writing her column, activities related to medicine account for a great deal of her time. At Harvard, she is on the Visiting Committee for Development and Resources. I asked her why she chose HMS in particular to hone her fund-raising skills. Like most of her responses, she is quick and straight forward: "I believe in supporting



Ann Landers

excellence. And I think that Harvard Medical School is the finest medical school in the world. I could have offered my services to any medical school. But I selected Harvard because I think that Harvard is number one. After attending many meetings, meeting many Harvard Medical School students, I am convinced that I was correct. After meeting the Harvard faculty members, again I'm convinced that I was correct. I made the best choice. There are other very good medical schools — Yale has a good medical school; Johns Hopkins is still good; the University of Minnesota has a good medical school; Chicago has a fine medical school; but in my opinion, Harvard is still tops. And I like to be identified, associated with, and work for the best." Not only does Ann Landers make a time and financial commitment to the School, but she has also made the ultimate in physical commitments. "I've often talked about the value of leaving your organs to an organ bank, so that when you go on, you can give someone else an opportunity for sight or life. I have stated in the column and from the speaking platform many times that when I die, I am leaving my body to Harvard Medical School."

There is a striking contrast built into the viewpoints of Ann Landers. On non-medical issues, she prides herself in being Midwestern, corny, and square. For example, she doesn't believe most people can deal with the emotional ramifications of premarital sex and if pressed, she'll even call it immoral. But on medically-related issues, she is

usually well informed and holds progressive views which many physicians her age (55) do not share.

She says, "There's a medical problem hidden in at least one-third of the letters." Her mail has made her especially aware of manifestations of psychosomatic illness in dermatoses, ulcers, migraines, and colitis. "Some girl, for example, who is 16 years old, will write and say she doesn't understand it, but just before every date, she gets nauseated and has to throw up. Or, another girl will write and say she can't eat when she's on a date — simply cannot swallow any food. She has no idea that it's emotional involvement. Some people get very tired and think they must have anemia. In order to do justice to this mail, I have had to learn about these illnesses and how they are related to life's problems."

She feels her readers are increasingly dissatisfied with their medical care because of the decline in the number of family physicians. Her readers miss the days when doctors made house calls. She reminisces about the time not so long ago when "the family doctor came when you called him. He sat down around the kitchen table with you, and he talked to you about whatever it is that you wanted to talk about. And often, what they wanted to talk about had no relation to the medical problem. It was another problem. He was a friend. He was a counselor. But today, because of the enormous load of paper work and the increase in population, it's impossible."

I asked Ann Landers how she felt about federal support for medicine specifically national health insurance. She gave her answer during the pre-Kennedy-Mills-compromise era. "I like Teddy Kennedy's bill very much. It is the most comprehensive. MediCredit is a good bill, which is the AMA's bill — less expensive. But now we have CHIP — this is Cap Weinberger's bill." She explained that "Cap is a good friend of mine. I'm constantly yelling at Cap to do this and do that and get on with that and get rid of this. And he's been extremely responsive, I must say. Better than I thought he would be, coming from the Bureau of the Budget. He is doing, under difficult conditions, really a good job. But she went on to say, as if to contradict herself, "I'm appalled by the cuts

in the grants for medical schools. This is a terrible thing that has happened. It's very expensive now to go to medical school. Many of the federal grants, as you know, have dried up completely."

She made one of her most enlightened remarks without the benefit of sitting through a year of organic chemistry, without having seen her friend's purified chemicals stolen after a hard afternoon in the laboratory. She says, "Some doctors should never have gone into medicine. There should be some psychological testing."

In terms of medical school curricula, she complains that students are not learning enough about sex counseling and psychiatry. By serving as the only woman on the AMA Advisory Board for Public Health from 1967 to 1971, she lobbied successfully for the AMA's publication of a book called *Human Sexuality*. She recounts her AMA experience with a satisfied smile.

"I've always been bitterly opposed to the AMA. I've always thought this was a little organization concerned only with themselves and their own interests. And I also knew. . . . that they were in part responsible for the shortage of what I felt were good medical schools. They kept the number of doctors down for a good many years. At least this was my notion. And I grew up not liking the AMA, thinking they were a right-wing reactionary group concerned with themselves and not with the health of the American public. So when I was invited to join the AMA, I decided I would accept the invitation. Instead of being on the outside and complaining, I thought the thing to do would be to get on the inside and see what I could do to improve it. Often this doesn't work, but I think in my case, it worked beautifully."

When I asked about the AMA's reaction to her preconceived notions she said, "They denied part of it. They admitted that some of what I had been saying was correct."

While serving on the committee, she made it known that her mail convinced her, "a great many people go to doctors with problems involving sex, and they come with some sort of a backache complaint or some complaint — something that is not really what they want to

talk about. They feel the family doctor will be able to advise them about their sexual problems, and they get into the doctor's office, and they find that the doctor is either uninformed or unwilling to discuss the problem."

She also pushed for more psychiatry in medical school curricula. "In today's medicine, there are a great many anxious people who are borderline something or other. I don't want to say schizophrenic, but they're mentally disturbed people. And I think that doctors should be taught to recognize the symptoms of mental illness. Many of them don't get it."

Her lack of awareness of women in medicine is her least progressive attitude, as the following exchange between us illustrates:

Landers: I would like to see doctors serving more in the capacity of family friends and counselors, because the doctor enjoys a position in the community that few men do. People just look up to the doctor. He's the smart man. He knows everything.

szg: Man or woman . . .

Landers: Man — oh, that's interesting. Now that *is* interesting. You see, now I said "man" . . .

szg: I've noticed you've been saying "man" the whole way through.

Landers: You see, that shows you how old-fashioned I am.

szg: One-third of the incoming class at the Harvard Medical School is women.

Landers: I know it. And I think that's marvelous. Women are going to make a big difference in medicine. They will be more inclined to listen. Also, a woman will be more comfortable talking to another woman about her problems than she is to a man. And she'll be able to talk about frigidity or impotence and a few things that some women can't even get the words passed their lips (sic).

For the remainder of the interview, she tried hard to include "women" when talking about physicians, but she would usually slip back to the male pronoun. It's a slip of the tongue that I bet most physicians her age would make, especially if they are affiliated with the less liberated medical schools.

While many middle-aged doctors would agree with Ann Landers when she calls for psychological screening of today's medical school applicants, their approval would fade quickly if they heard her talk like a young doctor or an enlightened federal official in favor of peer review and continuing education. In prodding her generation of physicians to accept these two valuable concepts, she is performing a badly needed service.

"I'm very much in favor of peer review, which the AMA was fighting violently for a while. But they saw the battle was lost, and that was that. Peer review was first tested in Oregon and ten doctors were not recertified. This was a shock to many physicians. They didn't realize there was such a thing as being excused from your profession for a few years simply to bone up and learn what it was that you didn't know. We're seeing new procedures; we're seeing new medicines; we're seeing new techniques. The doctor should be a continuing student. And those doctors who are continuing students practice first-class medicine. But many doctors, from the day they graduate from medical school, do not go to a meeting; they do not read any of the literature; they are out of it; they don't know about the new equipment; they don't know about the new techniques. I think medicine is advancing at a rather rapid rate. I think I read more medical literature than many practicing physicians. I'm sure I do. And I don't suggest that I'm reading that much. I'm suggesting that they aren't reading anything. It's tragic." Fortunately, Ann Landers is perceptive and courageous enough to call physicians on the carpet when necessary, thus showing more than blind praise and admiration for the medical profession.

After my interview, she embarked on an hour-long speech in front of more than 100 members of the Harvard Club. She told them about the challenges of writing an advice column. And when she brought before them a catalog of her reader's complaints, most of the audience became misty-eyed. One could hear frequent whispers of "that's true" and "she's right."

She mixed her philosophy with medical metaphors, saying, "Prosperity has grown a fatty tissue around our conscience. We seem to be suffering from a form of spiritual leukemia, a softening of the spinal column. And if all this adds up to a world that isn't quite as honest as it used to be, I apologize for disturbing you."

She blamed the television for "converting our society to a medicine chest culture. TV promises instant solutions and chemical answers to everything . . . If you're irritable, take a ComPoz — you'll save your marriage, get a promotion, and go to the party after all." She also criticized television for teaching people terrible nutrition habits. "They are being taught that it's all right to eat the whole thing" because "Alka Seltzer will take care of your stomach ache." And she deplored the children's TV commercials for promoting "candy-coated cereals, soft drinks, bubble gum, candy bars, potato chips — all the junk."

Mayor White chats with Ann.



Continuing her medical theme, she said, "I had no idea how many frightened stumbling people in this world needed help. I didn't know that millions of sufferers dragged their migraine headaches and their ulcers and their backaches to work every day."

All in all, I thought her speech sounded like a Rabbi's sermon on the High Holidays. It made people think uncomfortable thoughts and sensitized people to serious flaws in our society. When I told Ann Landers my reaction, she was disappointed and afraid that her speech was "too preachy."

At the end of her speech, Mayor Kevin White was supposed to present her with a Key to the City. However, the Key was being made to order for Ann Landers and it wasn't ready until after lunch. She had told me earlier that when White visited Chicago, she "threw a little party" for him, and he saw her cabinet of keys to cities. She describes it as "an extraordinary collection, actually. It's an enormous number and they're unique in that many of them are made for me, especially designed, instead of just these little things that you see." When White found out Boston was not represented, he promised to present a key during her subsequent visit to Boston. The key which she received was specially inscribed and mounted on a block of wood from the *USS Constitution*. Below the key was a small bronze city seal from the old Boston City Hall.

The day proceeded very smoothly, just as the officials of the Harvard Club had hoped, until about 2 p.m., when an uninvited member of Boston's Gay community asked Ann Landers a question to liven up her shy, polite, middle-aged audience. Barbara Piccirilli, office manager of *Gay Community News*, asked, "In most of your columns, you've come out and said that you think homosexuals are sick, although you do not consider them criminals. A lot of your columns are very anti-Gay. Would you like to comment on this?"



Demonstrators outside the Harvard Club.

Without skirting the issue, Ann Landers replied, "Yes, I believe they are sick." But at the same time she denied vehemently the charge of being anti-Gay. "I was the first columnist in the country to come out openly and say anything about homosexuality. This was 18 years ago. No one else would dare print this material . . . I was the first person in Illinois to go to the State Legislature, this was many years ago, and ask that homosexuality between consenting adults should not be considered a crime . . . Anything that two people do in the privacy of their own homes is their business. And I don't believe that homosexuals should be persecuted, should be fired from jobs, should be eliminated from a job list because this is their problem. I have been very sympathetic to homosexuals." However, she added, "I understand homosexuality is a human condition. But I do not believe it is anything to be proud of. And that's why I don't support Gay Pride."

The remaining hour of Ann Landers Day at the Harvard Club was punctuated by chants from a dozen demonstrators on Massachusetts Avenue, who shouted that "Ann Slanders Gay People." Linda Ray, another member of the Gay community, criticized the Landers viewpoint. Ray said Landers thinks "it's O.K. for us to have jobs, but we can't have any self-respect. And that sounds to me like just plain nonsense. You wouldn't say that to a Black.

But it's all right to say that to Gay people because Gay people are considered one of the last minorities. It's considered O.K. to oppress us."

The Gay demonstration illustrated again the dichotomy in Ann Landers' view: liberated on most medical issues but not quite as liberated on several important non-medical issues. Ann Landers admits readily, "I'm a square old bag back from the Stone Age. This is where I got my ideas. And being Middle West makes me very square. And I am Middle West, Jewish, square-oriented. This is the way I am, and there is nothing I can do about it."

When I asked her whether there would be a need for an Ann Landers for medical problems in an ideal world, she replied brusquely, "Of course not. In an ideal world, there'd be no need for an Ann Landers to deal with anything. Because I deal with problems. And in an ideal world, there'd be no problems. But we're never going to see it."

Regardless of whether one agrees with Ann Landers on a particular issue, one can admire her sincerity, hard work, and service to the thousands of people who write to her each week. While she is active on a one-to-one level, by having her staff of ten reply to every writer who gives a return address, she also remains active behind the scenes, trying to improve our society by pushing people and institutions toward nobler goals.

Scallop-Shell of Quiet

by George E. Gifford, Jr., M.D.

The poet and the mystic, both psychiatrists and amateur conchologists, walked the warm beaches of Florida in the 1940's. Having spent most of their lives with the convolutions and intricacies of the human psyche, the two found a joy in the symmetrical, clean lines and neat classifiability of sea shells. The friends were George Arthur Waterman, M.D. (HMS 1899) and Merrill Moore, M.D.

George A. Waterman (1872-1960) was "probably Boston's leading psychotherapist" in the 1920's.¹ The protege of James Jackson Putnam (1846-1918), Waterman was appointed assistant physician to the outpatient department at MGH and assistant in neurology in 1901. By 1915, Waterman was neurologist at MGH but in 1916, he severed all academic connections and went into the private practice of neurology and psychiatry. He gathered around him a brood of wealthy, dependent psychoneurotics who followed him from Pooduck Farm, his summer home in Brooklin, Maine, to Palm Beach, his winter home. Waterman retired from active practice in 1930, and spent much time in Florida where he became an ardent shell collector. A charter member of the American Malacological Union in 1932, he collected with B. H. Pilsbry, the great malacologist. With the Florida experts, Thomas L. McGinty and Maxwell Smith, he made numerous trips along the south east Florida coast and through the Keys.

Thomas L. McGinty wrote of Waterman:²

Dr. Waterman was one of the most delightful individuals it has ever been my good fortune to know. He was one of those rare types who seemed to have had a marvelous calming effect upon all he contacted, and somehow after you had just been with him for a while you felt wonderfully rewarded by the experience. We made numerous trips together in search of natural history specimens, our principal contact together, and each trip was a most rewarding experience for me. His innate consideration and politeness for others was always present. I vividly recall one

trip to a remote lighthouse to hunt for shells on the beach, and after our lunch, picnic variety, a large section of a beautiful juicy capon remained. Dr. Waterman insisted that we locate the light-keeper and give him the beautiful remains. He was that kind of person. I well recall how he would always ask his chauffeur to stop alongside the road for any accident we passed by. It made no difference that he might be dressed all in white . . . we would pause to see if any medical aid was needed. He was just one of those grand persons we so seldom ever meet — just a few like him more than compensates for some of the rest of us.

Several mollusks were named to honor Dr. Waterman by his Florida conchological colleagues: a fossil snail, *Fusinus Watermani*, collected at Belle Glade, was described by Maxwell Smith;³ McGinty described a living form, *Olivella Watermani*, a small glossy snail dredged off Palm Beach.⁴

Merrill Moore, M.D. (1903-1957), an active psychiatrist in Boston, was particularly interested in alcohol, syphilis, and suicide.⁵ Trained at Boston City Hospital, he held the post of assistant physician at the Boston Psychopathic Hospital (now the Massachusetts Mental Health Center). He went into private practice and maintained affiliations with the Harvard Medical School, Boston City Hospital, and Massachusetts General Hospital.

Because of their shared interests in conchology, psychiatry, and poetry, it was only natural for Waterman and Moore to become friends. At one time, Moore considered taking over Waterman's practice.

On their collecting forays, the two psychiatrists cogitated about shell collecting as a form of occupational therapy for their patients. Merrill Moore wrote an article, "Conchology as a Form of Occupational Therapy" for the *Journal of the Florida Medical Association*.⁶ Appropriately enough, the article bore a quotation that captures the calming effect of shell collecting — "Bring me my Scallop-Shell of Quiet — Sir Walter Raleigh."

In the article, Moore relates how Waterman pointed out that shell collecting could easily be used as an adjunct to psychotherapy in the private and institutional practice of psychiatry. Waterman detailed how he used shells in his therapy and Moore was "impressed by the artistic skill he had developed as a person, as a collector and as one who had learned how to direct the energies of the mind and use the resources of any situation toward helping persons become happier and better adjusted, especially those whose troubles were emotional in origin, men and women who were anxious, depressed, introspective, worried, apprehensive, irritable, and contrary."



Olivella Watermani

Waterman shared not only his shells, but also his patients with Moore, both at Brooklin, Maine and at Palm Beach. Moore described Waterman's methods as "so personal and so individually variable as to be almost indescribable objectively." Moore, however, was not intimidated by his own statement and did indeed describe Waterman's methods, which he readily acknowledged were superficial "but all beginnings are small. When one remembers that at the present time there are many types of neurotic personality and many neurotic reaction types, and that many of these are poorly understood, it would seem that new approaches should continually be tried in an effort to open more doors and throw more light on the dark closed chambers that hold the ultimate secret of neuroses."

It was Moore's belief that if Waterman's ideas and methods reduced the psychic suffering of one neurotic personality, it was justifiable. And Moore himself used these methods. In an article reporting

the case of a depressed man, Moore wrote, "One day I told him about the persona and anima as Jung described them. I used a shell to illustrate the idea, explaining to him that the persona was like the shell and the anima was the mollusk living in it. The idea was a revelation to him. He began to grow more aware of himself and his needs as a human being."

Moore wrote other articles⁷⁻¹⁰ on the efficacy of shell collecting as occupational therapy and educational articles on shells.¹¹⁻¹³ But the most lyric expression of his personal feelings about shell collecting appeared in "A Note of Conchology" for the *American Imago*.¹⁴



Fusinus Watermani

Cleaner than a hound's tooth; more sturdy than an apple, more solid than a brick, more chiselled than a piece of sculpture, more colorful than poetry, a shell defies description, exhausts comparison and abandons superlatives; it is itself. And the 'voice' of a shell is only a small part of a shell's charm. . . . If I wish to see richness in Nature, variety in patterns and seemingly endless alterations of color and line, all I need to do is to take them out and look at them. Among the riches of the earth I am amazed by Molluscan wealth, the treasures of the sea. Neptune rules over a mighty kingdom more of us earth-bound mortals would do well to pay him court. Sea shells are his Emisaries.

When Merrill Moore wrote this perhaps he was thinking of the frontispiece of a book he owned, a 1681 *Ricreatione Dell'Occhio, e Della Mente*¹⁵ (The Recreation of the Eyes and the Mind Through the Observation of Shells) by P. Filippo Buonanni. The frontispiece illustrated here is a mythological allegory. Two mermen support a scallop shell, emblazoned with the title, which

recalls the story of Venus, who rose from the sea upon a scallop, as depicted in Botticelli's, *The Birth Of Venus*. Rising from the sea in his golden chariot drawn by white horses, calming the surrounding seas, is Neptune, grasping his trident, scepter of his kingdom of the sea. Around him sport his son Triton, the herald of the sea, blowing his "wreathed horn," and his daughters, Rhode, Benthe, and Sicyme. In the foreground are probably represented the seated Amphitrite, wife of Neptune, holding an oyster shell bearing a pearl and kneeling next to her gathering shells is one of her sisters, a Nereid.

Merrill Moore was a distinguished and talented poet. He was the youngest member of the "Fugitive Group" of Nashville, Tennessee, who met and read their poems and for four years published their works in *The Fugitive*. His penchant for shells is revealed in his poetry. Henry W. Wells, Moore's biographer and critic writes in *Poet and Psychiatrist, Merrill Moore, M.D.*¹⁶

Out of the sea come shells, and to shells Moore has brought us no meager devotion. For to him shells are the lyrics of the sea, the strong glittering sonnets, seemingly delicate yet profoundly robust, profusely deposited upon the white or brown pages of the endless beaches. Shells are glamorous, musical, sensuous, but hard. Their exquisite beauty survives the sentient life that creates them. They are symbols, messages, poems. The Ocean broods with all its sombre glittering mind and creates a shell. Into the poets palm it falls. He reflects, is silent for a while, and at last speaks. For Moore shells are mysteries. . . . In his first published book [The Noise that Time Makes (1929)]¹⁷ appears a sonnet likening the convolutions of the shells to the complexities and distortions of the psychopathic mind. It is thus a sonnet central in Moore's intellectual view of life.

People like that develop much as sea-shells
Of curious shapes slowly come into being,
So slowly there is never any seeing
How it is done, but a slight incident tells
How much they are different, if you
know them before
Particularly,
Once, for example, they were thus:
A single whorl or two, no nucleus,



Dr. Waterman

But now they are elaborate monstrosities
Small and unrecognizable, except at the core
Which is invisible.

He only sees
Who remembers stage by stage how they became,
From namable forms, forms without a name,
Now ground by the ocean against an unending shore
To come the same particles they once were before.

It is tempting to liken this Freudian poem, which compares the shell to the human psyche to an earlier, anti-Calvinistic poem, "The Chambered Nautilus," by Oliver Wendell Holmes, which compares the pearly nautilus to the human soul. Holmes (HMS 1836), Parkman Professor of Anatomy and Physiology (1847-1882) and Dean of Harvard Medical School (1847-1853) wrote the poem in 1858. The pearly or chambered nautilus is a cephalopod of the South Pacific and Indian oceans, which builds a spiral shell, adding a chamber each year, and was thought by the Greeks to be capable of sailing by erecting a membrane. In this poem, the shellfish and man are bound by the same laws of progress, to strive for constantly higher attainments. Holmes develops a religious idea consistent with his revolt against such concepts as original depravity, predestination, and grace in the Calvinistic tradition. Here are some of the pertinent passages from "The Chambered Nautilus."



Dr. Moore

Year after year beheld the silent toil
That spread his lustrous coil;
Still, as the spiral grew,
He left the past year's dwelling for the new,
Stole with soft steps its shining archway through,
Built up its idle door,
Stretched in his last-found home, and
knew the old no more.

Thanks for the heavenly message
brought by thee,
Child of the wandering sea,
Lost from her lap, forlorn!
From thy dead lips a clearer note is
born
Than ever Triton blew from wreathed
horn!
While on mine ear it rings,
Through the deep caves of thought I
hear a voice that sings.

G. A. Waterman was one of the early pilgrims to Sanibel Island on the west coast of the Florida peninsula — a collector's paradise. Sanibel is the most southerly of a string of coastal islands running north and south, and by reason of its position, it is more favorably placed than any of the others to receive the wealth of shells washed up from the mid-gulf, forming as it does, a coastal barrier. The shallow gulf bottom, the southern exposure, strong currents, and a saline content favorable to molluscan life make the island unique in this hemisphere. The beach is literally a carpet of shells. It was here that Waterman was sometimes joined by Moore.

In a recollection of Moore written by Robert Frost, whom Moore had referred as a patient to Waterman, Frost records his memories of Sanibel and Moore's belief in the efficacy of shell collecting.¹⁸

On a visit to Sanibel he had the bright idea of shovelling up from the beach with his own hands a ton or two of sea shells and shipping them North for his patients to sort out. I wish you could hear the disc recording of his speech about the therapeutic value of this exercise in beauty. Possibly he thought it would do us the same kind of good to sort out the poems he left. Anyway I know he wouldn't mind my saying so.

The shells collected by Waterman and Moore are preserved today. Moore's extensive collection, including that of George Calvert, first Lord of Baltimore, an ancestor of his wife, is now in the Children's Museum in Nashville, Tennessee. In his will, Dr. Waterman left a bequest to the Brooklin, Maine Public Library of which he had been a board member for many years, for the purpose of building a room for books on the natural sciences and space to show his shell collection. However, the collection remains in a packing case in his niece's Maine home.

The friendship between George A. Waterman and Merrill is best celebrated in one of Moore's poems describing the nature of man and the form of sea-shells.

He picked up a handful of sea-urchin shells
and asked me if I knew the Dome of
Tamburlaine
And showed me one beneath a microscope.

There the arch was strong to stand the strain
And thus the turrets of mosque and minaret
Were built by this design that man had borrowed.

The architects had copied the sea shell
While lesser men had plundered and women sorrowed
In tents as walls were razed and cities fell.

Tamburlaine copies the shell meticulously to build its tower.

But no one can tell how
These creatures plan their shells and
lay their eggs
He said "The question every
philosopher begs. . . ."

Then we stopped to watch an osprey
strike a fish.

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Oliver Wendell Holmes Bookplate

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The Buonanni Frontispiece



Medical Negotiating at Wounded Knee

by John D. Asher '67

Co-organizer, Medical Relief Teams

I did not know then how much was ended.

Black Elk

It's a good feeling to walk on land that belongs to the people who live on it.

Bob King,
Wounded Knee medic

Introduction

We do not know now how much has begun.

By now many people know that toward the end of the last century there was a massacre at Wounded Knee, South Dakota. Over half of the 450 Indian women, men and children who had been herded together by troops of the 7th U.S. Cavalry were slaughtered by those same troops. The carnage that Black Elk was recalling in the quotation above occurred while the Indians were being disarmed four days after Christmas 1890. That day marked the last official butchery of Indians by the U.S. Government in the 19th century.

The first *official* Indian killing of the 20th century occurred in 1973 on Tuesday, April 17, at Wounded Knee, South Dakota. Frank Clearwater was mortally wounded that day in a fire fight between federal marshals and Indian forces inside Wounded Knee. He died eight days later of a gunshot wound to the head.

The seizure of the trading post and the surrounding settlement at Wounded Knee began on February 27, 1973 and was initiated by local Pine Ridge Reservation Indians known as the Oglala Sioux Civil Rights Organization (OSCRO) under the leadership of Pedro Bissonette.¹ They were aided by outside support from American Indian

Movement (AIM) leaders and from various sympathizers across the nation. For a variety of motivations, Chicanos, Blacks, and Whites all made their way to Wounded Knee in support of their Red brothers and sisters. Confronting them they found federal marshals in powder-blue jump suits with American flag shoulder patches, khaki-clad FBI agents slinging automatic weapons, walkie/talkie carrying Community Relations Service (CRS) men from the Justice Department, and Bureau of Indian Affairs (BIA) police, themselves Indians working with their affiliated toughs known locally as "the goon squad." The "goons" had earned their name by their rough tactics on anyone who disagreed with the Tribal Council and its leader Richard Wilson.

Somewhere between the opposing lines were the medical people, the legal people, and the church people. The closest to a local legal person was Ramon Roubideaux from Rapid City, South Dakota, who with a staff of lawyers represented the AIM interests. The local church and medical people

found themselves in a difficult position, since the Indian community itself was severely split into pro- and anti-AIM factions. The latter were led, of course, by Richard Wilson, whose ouster was one of the early and persistent objectives of the takeover. Pro-AIM Indians were mobilized by Pedro Bissonette under OSCRO. During the first few days of the blockade, medical personnel from the Indian Health Service Hospital in Pine Ridge, South Dakota, went to Wounded Knee. They stopped going after they got phone calls at night threatening their families and calling them "AIM lovers." Racism was nothing new on the reservation. Indians sympathetic to the Tribal Council and thus to the Government were disdainfully referred to as 'apples' (red on the outside and white inside). Families were sharply divided. The second Indian killed at Wounded Knee 1973 was Lawrence Lamont, a pro-AIM warrior who was also the brother-in-law of "Toby" Eagle Bull, a key Tribal Council leader and Richard Wilson's closest advisor.

Outside churchmen from the National Council of Churches (NCC) were led by the Reverend John Adams. He operated out of Pine Ridge, 17 miles from Wounded Knee. The Reverend Paul Boe was inside Wounded Knee. During the first few weeks before the BIA succeeded in removing him from the scene, Adams shuttled in and out in his two-way-radio-equipped station wagon, arranging meetings between Harlington Wood of the Justice Department and AIM leaders, while at the same time organizing his nonviolent "troops" of seminary student observers.

Inside churchmen, like the local medical personnel, were sensitized to the threat of repercussions long after the outsiders and do-gooders (like myself) were safely back in Minneapolis, San Francisco, New York, and the other urban centers from whence they had come. Thus they were reluctant to become identified with the militant Indians, though they freely admitted the corruption of the Tribal Council. Like the Reverend Adams, I, as a doctor from far away, had the advantage of acceptability based on my skills, trust as long as I delivered what I promised, and relative immunity to future revenge (except on the part of the Government — after all, I did cross state lines to get to Wounded Knee).

1. On 17 October 1973, Pedro Bissonette was shot and killed by a policeman of the Bureau of Indian Affairs. "Leaders and attorneys of AIM said Bissonette, 33, was 'assassinated' by the federal government." (*San Francisco Chronicle*, Friday, 19 October 1973).



What Did I Do There?

Day 1—Tuesday, March 13, 1973

I arrived in the small town of Pine Ridge, population 1500, at eleven in the morning without a single contact and with only one clue as to how to proceed. I had learned from the Frontier Airlines ticket agent in Scotts Bluff, Nebraska that there was an Indian Health Service hospital in Pine Ridge; the agent doubled as pilot for a small air ambulance charter service and had often flown sick Indians to Fitzsimmons Army Hospital in Denver: "They get the best care there is. There's no problem up there at Wounded Knee. There never was. We flew this old Indian lady to Denver. The government pays for all that, don't you know. Why even the *Americans* (emphasis mine) around here don't get care like that. Maybe you don't see it this way," he said eyeing my beard, "but I don't think they want to change. It's just like in Watts. There it was colored people, but it was started by outsiders. I'm 100 percent sure Communists are behind the whole thing. But when the trouble starts they're gone. This fellow Means is from Cleveland. He's not dumb by any means." Though his political analysis was incorrect, his information about the hospital turned out to be very helpful.

Being a Public Health Service graduate myself and also knowing that their hospitals are staffed with young doctors just out of medical school who are fulfilling their draft obligation in non-combat positions, I hoped to find a

friendly face or two to help me get into Wounded Knee. Moreover the basic rule taught me when going on assignment as an Epidemic Intelligence Service (EIS) officer with the Center for Disease Control in Atlanta, Georgia was to include rather than exclude the local health authorities. This old lesson turned out to be extremely useful as it opened the door to the various Justice and Interior Department officials who in turn granted me initial access to Wounded Knee. The second lesson I had learned as an EIS officer was to try to establish an enduring mechanism which continues after your departure. Once having gained entrance into Wounded Knee for myself and medical supplies, the setting up of ongoing medical relief teams became my main objective. In accomplishing it, by necessity I had to negotiate directly with all the major opposing forces and personalities at Wounded Knee, including Russell Means of AIM and Richard Wilson of the Tribal Council.

My immediate concern that first day, however, was to "get in." I headed for the hospital. The medical Chief of Staff, Dennis Noteboom and his wife Pat were both natives of South Dakota. Like many of the hospital staff they were concerned about the situation but not committed to the radical changes and tactics initiated by OSCRO and AIM. In the following days I often held real and hypothetical conversations with Dennis about the central issues which always confuse liberals in a confrontation: 1. Why use force? 2. Why the outsiders? 3. You can't beat the Government, can you? 4. Sure the Government has cheated, lied to, and murdered the Indians, but that was a long time ago. 5. What do they *really* want? All these questions have essentially simple answers, yet they are difficult to deal with quickly and glibly. To those of us who went in, the answers were implicit in our being there. They were hardly discussed, because they were assumed.

What did not become clear in my own mind until long after I left Wounded Knee and had spoken to groups in Ithaca, Washington, and in the San Francisco Bay area was the answer to that ever recurring question, "What do they *really* want?" Finally, after what seemed like hundreds of conversations I was able to answer it to my own satisfaction: They want what they deserve.

With the aid of Dennis Noteboom and Harley Zephier, the Indian administrator of the hospital, and Fran Olsen of the National Lawyers Guild, I got clearance into Wounded Knee late that Tuesday afternoon of my first day in Pine Ridge. It was getting dark at five in the afternoon when Fran and I drove through first the FBI lines barricaded by armored personnel carriers (APCs) and then the AIM lines blocked by two pickup trucks. The trunk and the inside of my car were searched, but we were not body-searched. Once inside, the medical group from the Bay Area and I had a joyful reunion. They had been bolstered by another M.D., Chuck Cowan, from a collective clinic in Seattle known as "Country Doctor Clinic." Over the next few days I developed great respect for Chuck's coolness and his dedication to the people he was serving.

After a two-way briefing Chuck and I sat down and made up two extensive lists, one of needed medical supplies, the other of food. I also examined two of the patients to help determine whether they ought to be transferred out. Fran decided to stay inside, as she was the only lawyer there. I left two hours later in a driving rainstorm, promising to return the next day with food and medicine. As I left, I experienced what I was to feel repeatedly each of the four times I left that brave band inside — relief and guilt: relief that I would soon be passing out of danger, and guilt that they would not. Each time I returned, the first question after "Did you get the cigarettes?" was "Are you staying in?" Just as anxious as the outsiders were to get in, the insiders were eager for them to come in — and stay with them.

Day 2—Wednesday, March 14

The driving rainstorm had changed to a blizzard with 60 mph winds. Nearly all traffic stopped, including 4-wheel-drive vehicles. I had been scheduled to get my supplies together in the morning and go in with a team from the hospital — a public health nurse and George Amiotte, an Indian medic. By the time the roads were passable it was evening, and it was dark, and there was no longer anyone to go with me. So I went alone. The FBI were impressed as much by my big black old-fashioned doctor bag (a hand-me-down from my father) as by the \$200 worth of medicine I had collected from the hospi-

tal. They ignored the six bags of food in the back seat. The AIM line was tougher that night. Outmanned, out-gunned, and a lot colder than the well equipped Feds, they were nervous and jumpy. Finally, in I went and out again three hours later. The woman with pneumonia whom I had examined the previous night was doing better, but we again worried about the possible legal risks should a patient become critically ill or injured and require transfer out.

During my three hours inside we had a major discussion about the need to maintain our medical credibility. The medic and the public health nurse who were to accompany me had planned to tend to the medical needs of Indians inside the perimeter who were not actively engaged in the takeover. Some patients requiring regular follow-up, such as a diabetic woman, an epileptic, and a hypertensive, had been unable to get to the hospital for their regular visits; they needed checkups and medication refills. One of these patients, the diabetic woman taking oral hypoglycemic agents, had been described that day in the national press as "four diabetics urgently in need of insulin." That distortion arose from our own group within Wounded Knee. I felt that crying wolf medically would undermine our present efforts and the long-range attempt to establish ongoing medical relief teams. It seemed crucial for us to keep our integrity with the national media intact, especially if events did lead to an all-out battle. So far as I know, no further medically inspired distortions occurred in the ensuing weeks.

Day 3—Thursday, March 15

The weather had cleared. The "land of changing seasons" was showing its spring face, almost as if to apologize for the nasty blizzard. Access to Wounded Knee had reverted to being a political rather than a 4-wheel-drive problem. It was a day of maximum negotiating. Off and on I had been pondering how to establish medical access as an ongoing process. My trip with the public health nurse and George Amiotte which was cancelled because of the weather gave me the idea I'd been looking for.

Wednesday night I had presented the idea to Russell Means, the AIM leader. My meetings with Russell tended to be rather informal; this one was in the

Wounded Knee infirmary in front of the drug cabinet where he had come to get some Vitamin C tablets. The trade I proposed was that the Tribal Council allow accredited medical teams to enter Wounded Knee in exchange for permission from AIM for the Pine Ridge hospital staff to care for nonmilitant patients within the Wounded Knee perimeter. The teams would consist of M.D.s, R.N.s, and medics with as many as six on a team. Russell pondered the suggestion about thirty seconds before nodding his head, "Yep, it sounds good."

Thursday morning I was invited to a meeting scheduled by Tribal Council Chief Wilson and his immediate advisors. In addition, Charles Soller, the top man from the Interior Department, and Stanley Lyman, the agent for the reservation, were also present. More important, at my suggestion, the hospital was represented for the first time; both Noteboom and Zephier attended. Their voices in favor of the access agreement provided crucial support for my plan; they agreed to take responsibility both for screening the incoming medical personnel and for processing all medical supplies shipped in from outside. The fear, of course, was that the outside medical people might be used to run guns and ammunition.

The meeting dragged on for almost two hours. The absence of John Adams of NCC was a disappointment and irritation to all sides. He had promised to come, but I knew that he was probably still tied up with Wood, the top Justice Department negotiator at the time. Moreover, he could not reveal this to the Council leaders. So I bided my time and thought about the post-midnight meeting I had had with Adams in Pine Ridge the night before, upon my return from Wounded Knee. I had asked him to support the medical access proposal and to assign one of his staff to do the on-site coordination of incoming supplies and personnel. I told him that People's Medical Center (PMC) and the Bay Area Medical Committee for Human Rights (MCHR) Chapter would handle the national coordinating. He was eager to help and extremely efficient in doing so.

Of all the complex characters who found their way to Wounded Knee, Adams was one of the most intriguing.

Possessed of enormous energy, at times acting like a prima donna and at others like a humble Christian, Adams was a brave and loyal worker. His word was good, and everyone knew it.

The meeting finally ended with no resolution but a promise from Wilson that the proposal would go on the agenda for the afternoon Council meeting. I was to return later to meet again with Wilson. I wrote a draft of the agreement and left for Wounded Knee to take in some anti-seizure medication for a young epileptic patient who had exhausted his supply.

While driving the 17 miles from Pine Ridge I thought about how I could nail down the medical access agreement, assuming I could persuade the Council to agree. Nothing was in writing, everything had been verbal, and I knew the Tribal Council would be less than enthusiastic. As I passed one of the media station wagons streaking down the Big Foot Trail from Wounded Knee, the obvious solution occurred to me: call a press conference, announce the agreement that all parties had agreed to, and use the forum to begin recruiting what came to be known as the National Wounded Knee Medical Relief Teams. Suddenly I felt in a deeply emotional sense the fundamental importance of a free press to a free society.

Once inside again I sat down with the medical team and discussed the content and strategy of the press release. The only argument concerned the amount of time each team should spend inside. One member felt that for sake of continuity future teams should be required to stay for two to four weeks. I thought this was totally unrealistic, in view both of how long people could be expected to drop outside medical responsibilities and of the enormous pressures acting on them once they were inside. We ended up "asking" each team to spend "at least one week in the Wounded Knee area." I believe the decision to relieve teams every week or ten days, though it did not allow for continuity, served other important purposes. A greater number of people had the opportunity to participate. Because the odds against the Indians were overwhelming, which meant that massive bloodshed was an hourly possibility, the pressure on the medical people was continuous and intense; a

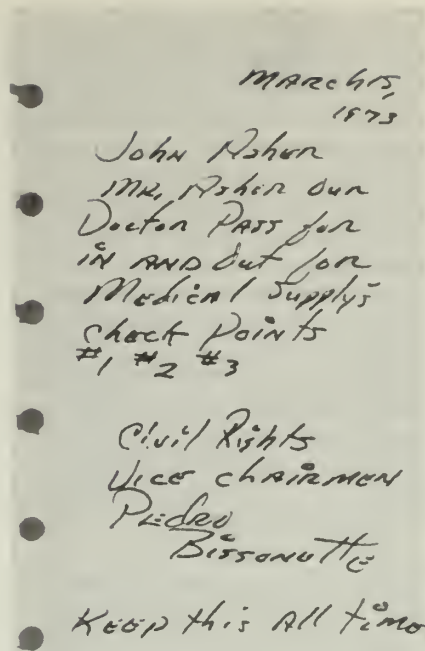
limited assignment, therefore, made the pressure more bearable. In a way the pressure was greater on the doctors, nurses, and medics inside because they were outsiders and in varying degrees remained outsiders. Thus they drew largely on each other for support and could not depend as heavily as the Indians on the whole community for emotional strength.

Having concluded my meeting with the inside medical team, I departed Wounded Knee for the first time in daylight; with faces and sunlight instead of forms and shadows, I felt somewhat safer but just as guilty. At four p.m. I was in Richard Wilson's office, still hoping to wrap up the agreement in time for the end-of-the-day press briefing. However, I had not properly gauged the workings of the Tribal Council. Richard Wilson had "forgotten" to bring up the issue of medical access at the afternoon meeting. I repeated all my arguments again, until finally, with an affirmative nod from "Toby" Eagle Bull in the background, Wilson agreed. That nod marked the first and, to my knowledge, the last negotiated agreement between the leaderships of AIM and of the Tribal Council during the first two months of the takeover.

I hurried to the press room, hoping to announce the agreement before anyone had time to change his mind. The 4:30 briefing was just breaking up, so we held the story until the next morning's ten o'clock briefing. This also promised to give us better coverage for the evening news programs.

Day 4—Friday, March 16

The press room was packed. Harlington Wood, then chief Government negotiator, was back in Washington, so the reporters were looking hard for other stories. I had asked the Reverend Adams to be there to explain NCC's role in coordinating personnel and supplies. My secondary purpose was to try to help legitimize his presence, as he was coming under increasing pressure from the Tribal Council. In fact, he was served with a court order later that day requiring him to leave the reservation. Within a week he and his ministry students were gone. At that time Adams and the Community Relations Service (CRS), the sensitivity wing of the Justice Department, had been responsible



Dr. Asher's pass.

for most of the behind-the-scenes negotiating which set up times and places for the Wounded Knee leadership to meet with government officials. In addition, Adams was a participant in all negotiations.

I read my prepared statement before the cameras, there were a few questions about my background, and that was it. Thus the "medical truce" was "initialed" and put into the public record. To a certain extent the agreement lasted, mainly because of the Government's cooperation in using their helicopters to get teams in and out. In the ensuing days and weeks the Tribal Council reneged by refusing access through the roadblock they set up after I left. Mike Silverstein, the doctor from PMC who took care of Frank Clearwater immediately after he was shot in the April firefight, had entered Wounded Knee by Government helicopter. The day Mike left he was driven out by CRS who promised him safe exodus through the BIA line. At the roadblock, however, he and a nurse were turned over to the "goon squad" and taken to BIA police headquarters, where the police attempted to intimidate them by suggesting that once they were through with them they might turn them back over to the "goons." After an hour or so they were released and told to leave the reservation.

After the press conference I made my final run to Wounded Knee, briefed the inside personnel on the press conference, and made a list of the medical team members for Soller from Interior. He had promised safe exit for anyone on that list, and his word was good. The team was ready to leave; we were expecting a new team that weekend, headed by Barbara Silverstein, a nurse from PMC who was to replace me as liaison person. She had been the national coordinator recruiting replacement teams, and she continued to recruit after spending ten days inside Wounded Knee.

Good Medicine Is Good Politics

The idea that medical personnel can be neutral in a confrontation is absurd. The BIA and Richard Wilson were quick to grasp this point, which explains why they reneged on the agreement I negotiated with them. However, the negotiations in and of themselves had a conciliatory effect on the general atmosphere by including two groups, the hospital and the Tribal Council, which had previously been excluded. Furthermore, the medical presence became a force to be reckoned with. Over the ensuing weeks the shuttling in and out of doctors, nurses, and paramedics provided a kind of "fair witness" which said two things to the Government: 1) There is middle-class support for this takeover, and 2) If there is bloodshed, assuming they live to tell the tale, the medical people will tell the world what happened. The Government knows very well that the medical personnel will be believed before the politicians, the negotiators, the lawyers, and even the media people. After all, it was the pathologist in upstate New York who destroyed the official attempt to blame the deaths of the Attica hostages on the prisoners. The story that their throats had been slashed was denied by the pathologist who ascertained the cause of death to be bullets — and only the police had guns.

Unlike lawyers, doctors are not trained in the adversary mode; they tend to cooperate with other doctors in order to defeat a nonhuman adversary, namely disease. Rather than covering up or distorting truth, their efforts are aimed at discovering reality and, when possible, the true pathological mechanisms at

work. This is not to picture doctors as ever noble defenders of truth and lawyers as consistent liars, but it is important to recognize the intrinsic difference between the adversary negotiator's attempt to portray the best story or to get the best deal, and the scientist's effort to picture reality as distortion-free as possible. Nor does this mean that lawyers are more biased than doctors in a confrontation. On the contrary, doctors and other medical personnel take a clear stand merely by being there. Negotiators are not usually shot at, whereas medical personnel at Wounded Knee were pinned down more than once by Government fire.

In short, the basic point is that the standing of medical personnel in the community at large is such that they tend to be more credible by being perceived as more "scientific" in their approach. Thus, they pose a distinct threat to any official attempt to lie or cover up. As I pointed out earlier, this is valuable power which must be protected, for it is easy to squander by exaggeration, as in the case of the diabetic patient.

In an armed confrontation, therefore, good medicine is good politics, because in addition to direct physical support it provides legitimacy, and thus important psychological support to the "rascals, scoundrels, felons, and other troublemakers" (as Interior Secretary Rogers C. B. Morton termed them) causing the insurgency.

Observations and Conclusions

One wonders why? Why violence? Why Indians armed with hunting rifles and one AK-47 versus "Americans" carrying M-16s and machine guns? Why, as was often predicted in the middle sixties, had the war come home? Why, to very loosely paraphrase Malcolm X, was the Indochinese chicken roosting in South Dakota?

Regardless of the issue — civil rights, Vietnam, job or housing discrimination — the necessity for militance and violence has in every case arisen from two causes: first, survival is felt to be at stake; second, *nothing else works*. The

reasons why the system doesn't work are complex and obviously go far beyond both the personalities of those in power and the scope of this article. The fact remains that violence for political purposes, as at Wounded Knee, is always a last resort. This makes perfect sense when one considers that the status-quo powers always outgun, outman, and outmedia the insurgents, whether at a prison, a university, a hospital, or at Wounded Knee. The risk to life, limb, and liberty is taken mainly by the radicals. Why should they take violent action until forced to do so, when the chance of winning any isolated skirmish is so small and the chance of being hurt is so great?

Vietnam as a paradigm for Wounded Knee is both painfully obvious and almost banal, but it must be emphasized and reiterated until the essential truth gets through to the American people. That truth is that oppression abroad and oppression at home are inextricably linked. Imperialism and racism may not yet be household words, but the linkage binding Vietnam and Wounded Knee, forged out of economic exploitation and racial hatred, is becoming increasingly apparent to more and more Americans. Whether it involves bombing defenseless Indochinese, massacring hapless Indians, shooting unarmed college students, or murdering prisoners and hostages indiscriminately, all the corpses look alike.

Still one questions why the U.S. Government was so threatened by a forty-acre takeover? The answer is in part "law and order" and in part "the domino theory." Also at stake, however, is economic interest in the sovereign control of an additional 54,999,960 acres of valuable land.

"It has often been said, with considerable truth, that there is big money in 'Indian business.' The Indian tribes still own more than 55,000,000 acres which, with their water, minerals, timber, grazing lands, and other natural resources, represent a sizable portion of that part of the nation's territory which is still largely unspoiled, unexplored, and unpolluted. For many years the acquisition of these resources has been the objective of numerous non-Indian users, whose pressures and tactics, often questionable if not outright fraudulent, have brought them into serious conflicts with the Indians. Inevita-

bly, the conflicts have turned the white interests for help to Senators and Congressmen of the Interior Committees and to friendly officials of the Department of the Interior or other agencies of the Administration, and almost as inevitably the Indians have suffered." (Alvin M. Josephy, Jr. "What the Indians Want." *New York Times Magazine*, March 18, 1973.)

Once again at Wounded Knee the "white interests" turned to "friendly officials," and once again the Indians suffered. The difference this time was that Indians themselves forced the confrontation. Rather than being massacred again, they used every weapon at their command — law, medicine, religion, media, and the gun — to force their presence into the American consciousness. No longer content to serve time obediently in their rural concentration camps, they are serving notice on the American people and government. As Vernon Bellecourt, one of the national AIM leaders put it, if there are no significant changes by 1976, then AIM may just blow out the candles on white America's 200th birthday cake.

Abnormally short life expectancy, high suicide rates, widespread malnutrition, astronomical unemployment, substandard housing, totally inadequate education — this familiar catalogue of despair applies equally to rural ghettos and to urban slums.

Perhaps more understandable than the statistics of life and death on the Pine Ridge Reservation is the following anonymous poem I copied from the wall of the BIA building in Pine Ridge:

In the western part of South Dakota
Pine Ridge Reservation is the spot
Where we are doomed to spend our
time
In the land that God forgot.

There is hardly any employment here
For the gallant Oglala Sioux
A million miles from nowhere and
A thousand miles from you.

But when the pearly gates are opened
And our life on earth is through
Our tears will turn to laughter for
This time the joke's on you.

For when we get to Heaven
You'll hear Saint Peter yell
"Come on in you Oglala Sioux
You've served your time in Hell."

Boston City Hospital: Part IV

by Norman G. Levinsky '54

Wade Professor and Chairman,
Division of Medicine,
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In the Jan/Feb issue of the *Bulletin*, three members of the Harvard faculty described their perceptions of what happened at Boston City Hospital. Like blind men describing an elephant, each of us involved in the events of February 1973 perceives them differently, according to his individual vantage point. Mine is that of a graduate of Harvard and its teaching hospitals, who found himself on the other side of the BCH academic battle. A member of the Boston University staff at BCH for the previous 12 years, I served as chairman of the Ad Hoc Committee hastily assembled by BU to prepare the proposal which the BCH Trustees had suddenly requested from each school.

As a Harvard man, I can understand the shock and grievous disappointment of Harvard loyalists over the decision to award professional responsibility for BCH to BU. How can any institution give up 109 years of association with the premier medical school in the United States, especially when that relation had produced a world-renowned center of academic excellence in the Thorndike Memorial Laboratory? I have enough of that "Harvard arrogance" of which Dr. Epstein wrote to consider these legitimate questions. Not enough, however, to believe that the choice of BU over Harvard is so obviously irrational that there must have been some unfair advantage, some political chicanery by BU.

Presumably it is this assumption that leads two of the writers in the Jan/Feb 1974 *Bulletin* to hint or to state outright that BU had had prolonged secret negotiations with BCH administration or with political figures without the knowledge of the other schools and had prepared a secret plan long in advance. Remembering the frenzied atmosphere surrounding the meetings of the BU/BCH Committee we hurriedly assembled, remembering that February weekend I spent writing draft after draft

of our hastily concocted plan, I can only react with a mixture of wry amusement and irritation to the suggestion that we had merely to pull a well-prepared treaty out of a secret file. All three of the schools had long been aware that key BCH trustees and administrators had increasingly questioned the three-school setup as the Hospital had decreased in size over the years. Informal discussion of the pros and cons of assigning administrative responsibility to a single school had proceeded sporadically for years among all elements of the Hospital constituency — medical staff from all three schools, administration, and trustees. With intense pressure from the City Administration to limit Hospital expenditures early in 1973, discussion of one-school professional responsibility increased. Perhaps because the years of discussion without action made it impossible for the medical staff or the Dean's Offices to believe that this time the trustees were prepared to "bite the bullet," all three schools appear to have been caught flat-footed by the request for a proposal on very short notice. In any case, that was certainly our situation at BU: we had no advance notice and our response to the trustees was generated *de novo* at the last minute.

What rational, non-nefarious considerations could have convinced the Trustees of BCH to choose BU to lead its future as Harvard had led its past? Harvard/Thorndike alumni must recognize that both BCH and Boston University Medical Center had changed dramatically over the decade or two before the crisis. The in-patient census at BCH had fallen from 1200 to 600. University Hospital, once a modestly equipped 180-bed facility, had become a 350-bed major medical center, similar in size and scope of activities to the Peter Bent Brigham Hospital or the Beth Israel Hospital. Together, BCH and UH were somewhat smaller than the Massachusetts General Hospital,

but were administered entirely without relation to one another. Therefore, within one block on Harrison Avenue: 3 hemodialysis units, 2 cardiac catheterization facilities, 2 cardiac surgical teams (with the same surgeons), 2 radiotherapy units, etc., etc. Even the most superficial area planning indicated both the administrative desirability and the probable cost-effectiveness to both hospitals of combining some activities. While any one of the three schools could have achieved some economy by elimination of triplication within BCH under one-school management, only BU could offer the advantages of combination with the neighboring UH.

Another factor to be considered by the trustees was the extent to which each of the three schools was already responsible for professional services at BCH. At the time of the crisis, BU supervised about 60 per cent of these services: pathology, obstetrics, radiology, pediatrics, urology, thoracic surgery, pediatric surgery, ophthalmology, and one-third of medicine and general surgery. The reasons for the decline in Harvard's previous dominance at BCH are controversial: Dr. Epstein suggests that concern with the needs of Boston University School of Medicine caused Harvard to turn over some key services to a sister school; Dr. Kass suggests a component of misjudgment and relative disinterest in BCH by key Harvard faculty and administrators, cumulative in effect over the years; less charitable members of the Harvard faculty have suspected a long-term surreptitious and skillful campaign by BU to take BCH over piecemeal. As a Harvard alumnus, I like to think that Harvard, with its unparalleled wealth of alternative teaching facilities, responded with generosity to the growing needs of BUSM, whose class size has nearly doubled in the past decade. It also seems reasonable that, as BCH decreased in size, its relative importance and influence in the Harvard orbit decreased, leading to the repeated Harvard decisions against maintained support and replacement of key faculty to which Dr. Kass alludes. With fewer alternative teaching facilities available, BU necessarily put more of its efforts and a larger share of its funds into BCH than would have been appropriate for Harvard, with its multiple affiliates. Thus, BU put the chairmen of its entire departments of radiology,



B. U. Medical Center

pediatrics and obstetrics at BCH. This was quite appropriate to the relative importance of these BCH services to BU, but was obviously unthinkable in the Harvard orbit, in which larger services existed in each department at several other hospitals. Again, although the prestige of its historic glories still gave the Harvard Medical Service greater external glamour, within the BCH there was general recognition by 1973 that the BU Medical Service was at least as good, as deeply staffed and, possibly, had better morale. As to the conspiratorial theory, I reject it, if only because during my dozen years at BU I detected evidence neither of such a campaign nor even of the skillful political conspirators necessary to mount this type of effort. My own view is that the growing involvement of Boston University Medical Center in the affairs of BCH was largely the result of the geographical facts and their consequences: BU and BCH are neighbors with common problems for which there may be common solutions.

In any case, whatever the causes, the facts were clear. If any one school was to have total responsibility, it would be least disruptive of the existing situation at BCH if that school were BU. Moreover, by 1973 less than 30 percent of Harvard clinical teaching was at BCH, whereas more than 60 percent of

BU instruction was carried out at the Hospital. Loss of BCH for student teaching would have been a crushing blow which could have threatened the viability of the Boston University School of Medicine. The social costs of near-catastrophic disruption of teaching at one of Boston's three medical schools was another rational factor the BCH Trustees had to weigh in making their decision.

Whatever the reasons, the Trustees of BCH have made their decision. What has happened at BCH since February 1973? It had been the position of the BCH Trustees and of the three schools that, whichever one was awarded responsibility, all three should be welcome to continue teaching at BCH. Realistically, it was recognized that none of the schools would be likely to continue for the long term major commitments to a hospital where it lacked any control but, for the immediate future, each school had expected to maintain some involvement. The medical and surgical specialty services, each previously managed by one school, have continued essentially unchanged. Harvard chiefs still head the departments of neurology, neurosurgery and medical microbiology, Tufts chiefs the departments of orthopedics, otolaryngology and dental surgery. Working relationships between

them and their BU colleagues have been neither more nor less harmonious than in the past, depending more often than not on the individual personalities concerned.

Medicine and general surgery were a different matter. Each school had its own staff, its own chief of service, its own esprit. To suddenly combine under a single leadership proved impossible; the years of inter-service rivalry, the rancor stirred by the sudden contest for supremacy, could not be submerged overnight. One decision especially hard for Harvard to accept was the end of a separate Harvard medical house staff * and Harvard wards. Perhaps there are no arguments which will convince Harvard, and especially Thorndike, alumni that the decision to end this glorious tradition was anything but a hostile gesture, a lack of magnanimity and of respect for academic tradition by BU faculty. I should emphasize, however, that the history and the costs of inter-service rivalry were well known to BCH Trustees and administration. Since cost savings from amalgamation of medicine and surgery were a key purpose of their decision, the BCH Trustees and administration were adamant against continued identification of separate wards and staff. Moreover, it is not hard to imagine the impossible administrative position of a chief of medicine, if

*Dr. Epstein writes that "intern applicants to the Harvard medical service for 1973-74 were immediately scratched from the BCH matching plan list, and BCH interns were selected from applicants to the BU service, together with a few applicants to the Tufts service." In fact, a full roster of applicants to the Harvard service was originally included on the BCH matching list. Only after Dr. Epstein had sent each applicant a telegram which, it was feared, might discourage them from ranking BCH was the Harvard list virtually withdrawn, out of concern that one-third of the internships might remain unfilled through the matching plan. The Tufts list was interdigitated with the BU applicant list without discrimination. All previous commitments to Harvard and Tufts house officers for residencies during the current (1973-74) academic year were honored, and all but a few chose to remain at BCH. Moreover, a number of those who, in 1972-73, were interns on the Harvard service have decided to remain at BCH during 1974-75 as senior residents.

two-thirds of his house and senior staff were recruited separately by and were loyal to someone other than himself and the institutions he represented. No agreement could be reached and Harvard decided to pull out of medicine and surgery sooner rather than later.

Another painful issue for which no satisfactory solution could be found was the fate of the name "Thorndike Memorial Laboratory." To Harvard faculty at BCH, to generations of Thorndike alumni and, no doubt, to the academic medical community at large, the Thorndike meant Harvard, and the separation of Thorndike from Harvard was an unthinkable act of desecration. But the Thorndike is an intrinsic part of the history of the BCH as well as of Harvard. It was the first research institute in a municipal hospital in this country. As Dr. McDermott pointed out, the city fathers at the time of its creation considered it a source of "... righteous pride and real glory (to) Boston." No less do the current Trustees consider the Thorndike spirit and the name, engraved in stone on a BCH building, part of the glory, tradition and uniqueness of the Hospital. Determined that the Hospital shall continue to stand for excellence in clinical research in the future as it has in the past, the Trustees have insisted that the Thorndike name must remain at BCH, the institution to which it was originally given.

What has been accomplished during the first year under the new professional aegis to implement the goals of the trustees in their decision and to meet the challenge of improving medical care at the Hospital? The limitation to 500 beds at BCH has posed few problems; the census has remained high and relatively constant this year. Occasional patients who could not be accommodated at BCH were transferred without difficulty to University Hospital or to other cooperating hospitals. The plan for integration within BCH and between BCH and UH has progressed, with cost savings and improved services to both Hospitals. A few examples can be cited. The medical service at BCH is housed in a single, renovated building; the former three small medical intensive care units have been consolidated and improved. Pathology services for both BCH and UH are centralized in the Mallory Institute at BCH. Dialysis, cardiac cath-



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eterization, open heart surgery, and radiotherapy are performed for both groups of patients at UH. Each of these programs was previously too small at BCH to justify the resources and maintain the skills necessary for optimum specialized care. The general and speciality training programs for house officers now take advantage both of the specialized patient population at UH and of the exciting acute medicine at BCH. The previous three medical and three surgical clinics at BCH have been integrated. In general, ambulatory medicine has been reorganized to improve patient care and full-time staff are heavily involved both in direct care and in supervision of house staff. A major new training program in medical and pediatric primary care has been established and funded both by federal and by foundation grants. Clinical and laboratory research continues to flourish; despite the national funding restrictions, the BU Clinical Research Center has long-term support and important new programs in endocrinology, rheumatology and cardiology, among others, are being added.

I cannot share Dr. McDermott's pessimism that BCH is in an "agonal phase." On the contrary, it is as lively, as exciting and as important as ever. I agree with Dr. Kass that the integration of a private hospital like UH and Boston's only municipal hospital is a "bold experiment." I would go further and argue that it is a necessary one if we are to achieve one level of first-rate medical care for all. In the coming age of national health insurance for all, municipal hospitals will survive — and deserve to survive — only if they measure up in every respect to their private neighbors. If the urban dilemma is the toughest problem of our lives, as Dr. Epstein suggests, Boston City Hospital will still be the place to come for trainees who want to understand and help resolve its medical aspects. Some Harvard alumni, anyway, seem to agree — four of the outstanding group of new medical interns next year will be Harvard graduates.

